

**Investigation into the circumstances surrounding the
death of a woman at HMP Send in April 2007**

**Report by the Prisons and Probation Ombudsman
for England and Wales**

July 2009

This is the report of an investigation into the death of a woman at HMP Send in April 2007. The woman was discovered by staff suspended by bedding from her bathroom door. She was taken to hospital but, despite efforts to resuscitate her, she was pronounced dead. The woman was 32 years old.

I offer my sincere condolences to the woman's family and to all those touched by her death. One of my Family Liaison Officers has remained in contact with the woman's family. I apologise to them and to others for the considerable delay in producing this report. However, I hope it helps provide a clearer understanding of the events leading up to the woman's death.

The investigation was undertaken on my behalf by one of my Senior Investigators. In addition, a clinical review panel, chaired by a member of the local Primary Care Trust, undertook a review of the healthcare the woman received whilst in custody. A Consultant Forensic Psychiatrist provided an independent opinion on the mental health care offered to the woman. I would like to thank the then Acting Governor of Send and her staff for their help and co-operation.

The woman's death was the second of three apparently self-inflicted deaths to have occurred at Send since I took over responsibility for investigating all deaths in prisons in April 2004. All three women had significant histories of substance misuse, mental health problems and self harm. They experienced varying degrees of bullying by other prisoners whilst at Send and struggled with unresolved issues of loss of close relationships and separation from their children. All three died in a similar manner after being found attached to ligatures secured to bathroom door handles. (As a result, individual cell bathroom doors were removed in October 2007.)

I note that the woman shared many of the vulnerabilities identified by a report on women in the criminal justice system, published in March 2007. The report called for a distinctive woman-centred approach to woman offenders given that "... relationship problems feature strongly on women's pathways to crime ... drug addiction plays a huge part in all offending and is disproportionately the case with women ... mental health problems are far more prevalent ... [and] self-harm in prison is a huge problem and more prevalent in the women's estate" . Based on a like analysis, the Prison Service issued its first comprehensive policy (PSO 4800) on how it should meet the different needs of women prisoners in April 2008.

This is a report that I hope will be widely read by those in the Prison Service with responsibility for women's prisons. I make 12 recommendations and highlight an area of good practice in relation to the investigation of bullying.

This version of my report, published on my website, has been amended to remove the names of the woman who died and those of staff and prisoners involved in my investigation.

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Prisons and Probation Ombudsman

July 2009

CONTENTS

Summary

The Investigation Process

HMP Bronzefield

HMP Send

Key Events

The woman's previous periods in custody at HMP Bronzefield

The woman's period of custody at HMP Send

The woman's first month at Send

The woman's stay in the Addiction Therapy Unit

The woman's return to A wing

The events in April

The discovery and aftermath of the woman's death

Reflections from the woman's family and friends

Issues

Clinical Review

Recommendations

Good Practice

Documentation considered during the investigation but not annexed

1. Transcripts of police interviews
2. List of previous convictions
3. Inmate Information System record
4. Note of conversations with staff at HMP Bronzefield on 21.8.07
5. PPO reports of previous deaths at HMP Send
6. Her Majesty's Chief Inspector of Prisons' report – Bronzefield, June 2005
7. Her Majesty's Chief Inspector of Prisons' report – Send, February 2006
8. The Corston Report, Home Office, March 2007 - A review of women with particular vulnerabilities in the Criminal Justice System.
9. Prison Service Order 2700 Suicide prevention and self-harm management
10. Prison Service Order 2750 Violence reduction
11. Healthcare Needs Assessment, HMP Send 2006
12. Medicines Management in HMP Send - Improvement in the delivery of medicines to prisoners, September 2005
13. Staff detail April 2007
14. HMP Send contingency plans
15. Serious incidents report forms
16. Record of Events 8 March - 18 August 2006

17. Record of Events 30 June - 13 August 2006
18. Record of Events 14 August - 30 September 2006
19. Record of Events 1 October – 25 February 2007
20. Confidential Medico-legal addendum psychiatric report
21. Copies of personal letters
22. F2058 Security Record
23. Security Information Report found outside security office on 20 April 2007
24. Anti Bullying investigation documents
25. Closed F2052SH self harm booklets
26. IEP Board decision on downgrading
27. RAPt client file
28. National Probation Service records
29. Notices to staff and prisoners
30. Reception interview – HMP Send
31. First Night and Induction Needs analysis – HMP Send
32. Notice from the fifth Officer to other staff regarding issuing of razors to the woman
33. Custodial Documents file
34. Sentence Management Dossier
35. Previous prison records 2005

SUMMARY

Before the woman came into custody, she had a history of drug use and depression after experiencing bereavement due to the loss of close relationships.

The woman was remanded in custody to HMP Bronzefield in March 2006. Her trial received significant media coverage and she asked to be segregated for her own protection after being convicted of a number of offences related to supplying drugs and child cruelty. Although she had spent three previous periods on remand, it was the first time she had received a custodial sentence.

The woman was transferred to HMP Send in October 2006. She faced bullying over several months from other prisoners because of her offences. Some of these prisoners were identified and warned about their future conduct.

As the woman was regarded as at risk of self-harm or suicide, she spent several periods being regularly monitored by staff using a document called F2052SH (later replaced by the Assessment, Care in Custody and Teamwork policy (ACCT)).

The woman applied to undergo a programme to tackle her drug misuse and was accepted into Send's Addiction Treatment Unit. Shortly after beginning the programme, however, she began to cut herself with razors. Due to this behaviour, she was unable to continue the programme but the Treatment Manager encouraged her to return when she felt mentally stronger.

The woman moved to A wing where she would harm herself periodically with anything that came to hand such as pins, razors, coffee jars or broken mugs. Although she eventually made a small group of friends, the woman was unable to shake off the feeling that she was at risk of being attacked by other prisoners. This meant that she remained on the wing and was reluctant to take her meals in the dining hall which was in a separate building. The woman had regular sessions with a Community Psychiatric Nurse to address her mental health issues. However, she missed several appointments.

On 22 February 2007, the woman's cell was searched and 47 tablets, two razor blades and ripped up bedding were found. An F2052SH was opened that day. The documentation was changed to the new system (ACCT) on 26 March. In an assessment interview, a prison officer asked the woman about her suicidal thoughts and intentions. The woman said that if things went "horribly wrong" in prison, she had a plan to hang herself from her bathroom door or an outside stairwell. She was initially observed three separate times during each morning, afternoon and evening period, and hourly during the night.

Send received a letter from the woman's mother on 10 April, detailing her concerns about the woman's appearance and depression. On 11 April, after a case review, the frequency of observation was reduced to once every morning, afternoon and evening, and three times during the night.

On 18 April, the woman was found hanging from the bathroom door of her cell. Despite resuscitation attempts by prison and ambulance staff, she died in hospital in

the early hours of 19 April. On 20 April, an undated Security Information Report written by a Nurse was found outside Send's security department saying that the woman had been seen with medication in her mouth during the morning medication round.

A post mortem report found very high concentrations of fluoxetine (an anti-depressant) and zopiclone (medication for insomnia) in the woman's body.

THE INVESTIGATION PROCESS

1. My investigator was given access to the woman's prison records covering her time at HMP Bronzefield and HMP Send including her clinical record, statements from staff and other documentation.
2. Notices to staff and prisoners announcing the investigation were displayed around HMP Send. No written responses were received. My investigator met representatives from the prison's Independent Monitoring Board (unpaid members of the community who are appointed to each prison to ensure that prisoners are being treated humanely) and the local branch of the Prison Officers' Association to offer them the opportunity to raise relevant issues.
3. One of my Family Liaison Officers made contact with both the woman's mother and partner. The woman's mother spoke positively of the support they had been offered and said that Send had answered their questions sensitively. They both accepted the opportunity to contribute towards the investigation process.
4. The woman's mother said she had seemed happy and looked healthy at Bronzefield. This was in contrast to the "pitiful state" of her physical and mental well-being after her transfer to Send. After the woman's death, her mother had received a letter from a prisoner mentioning that the woman would not collect her meals so other prisoners would give her food. She questioned whether this had been picked up by staff. Her mother felt that the lack of contact between the woman and her son had been a significant factor in her rapid decline at Send. She had written to the duty governor a week before the woman's death as she was very worried about her daughter, but did not receive a reply. The woman's mother questioned why she had not been moved to a more suitable environment given that she was clearly struggling at Send and did not want to be there. She wondered whether the frequency of observation checks on the woman had been sufficient.
5. The woman's partner had several concerns about her life in prison. He did not think prison was the right place for her and felt that an example had been made of her of due to her high media profile. He was concerned that telephone contact between himself and the woman had been stopped for a few months by Send without proper explanation (the restrictions were lifted eventually). He did not think the woman had been properly risk assessed given her vulnerability, and she should not have been left alone for long periods in her cell or given razor blades to use. He felt more thorough consideration should be given to items available to prisoners, such as razor blades and glass jars that might help them to self-harm. He thought that the woman would have found living in such a small cell very difficult, especially when she was feeling low. The woman's partner was angry to learn that her Incentives and Earned Privileges level had been downgraded on the anniversary of the date she gave as that of her daughter's death. After the woman's death, he had been told by a prisoner that the woman was supposed to be checked every two hours but the last check before she was found had been missed. He had also been told by a prisoner that the woman had a

session with a psychiatrist the day before she died, and that she had found this particularly intrusive and upsetting. He regarded this as a possible contributory factor to her death as she had been left unsupported and unsupervised after the session had finished. He felt angry that it had taken three deaths at Send before the cell bathroom doors were removed. The woman's partner said that during his visits to see her, she mentioned having suicidal thoughts and was "very low". She had told him, however, that healthcare staff at Send were aware of how she was feeling. In retrospect, he felt guilty for not bringing this to the attention of prison staff at the time.

6. After reading a draft version of this report, the woman's mother described the events leading up to her death as a catalogue of mistakes. She was surprised by the lack of communication and information sharing between Bronzefield and Send prior to the woman's transfer. She was shocked to learn that no special provisions were made for the woman's arrival at Send, given her vulnerability. The woman had been regarded as a high profile prisoner at Bronzefield but had been moved to Send after her conviction where "nothing was put in place to protect her." Yet there was another high profile prisoner who remained at Bronzefield which she described as a "remand prison". The woman's mother felt exceptions should not be made for some prisoners over others.
7. She was shocked to learn of the limited psychiatric support available at Send as it seemed woefully inadequate to meet the specific and complex needs of vulnerable female prisoners. She felt there should be a daily mental healthcare presence to ensure that the women had access to support when they needed it rather than days later when their distress might have escalated. She questioned whether the woman really was strong enough to have undergone sessions with the Community Psychiatric Nurse, given her distress after the sessions. The woman's mother asked whether individuals were assessed sufficiently before undergoing such sessions.
8. The woman's mother got the impression that Send staff tended to distance themselves from the prisoners and did little to get to know them as individuals. The woman had not told her about the bullying or difficulties she was experiencing at Send but if she had, her mother said she would have done something about it. She was disappointed about Send's efforts to identify the perpetrators and considered that placing an officer inside the woman's cell rather than somewhere where they could see what was happening did not make sense to her.
9. The woman's mother questioned whether her medication was being monitored properly. She thought it seemed inconsistent and thought that the woman might have not felt so down if her medication was better regulated. She was concerned that the post mortem had found high levels of the anti-depressant, fluoxetine in the woman's blood.
10. Finally, the woman's mother wanted to know why only one member of staff carried a full set of keys at night. She said that we would never know whether

more immediate action might have saved the woman and it could mean the difference between life and death for someone else.

HMP BRONZEFIELD

11. HMP Bronzefield is a purpose-built women's prison in Ashford, Middlesex. Opened in 2004, it is a privately-run prison managed under contract by Kalyx, and holds 465 women. All cells in Bronzefield are safer cells, which mean that they are designed to contain as few points as possible to which a ligature can be tied.

12. Her Majesty's Chief Inspector of Prisons carried out an unannounced inspection on 13-17 June 2005. The report of the inspection said that, although prisoners at Bronzefield had a poor perception of the quality of healthcare, the staff were caring, highly motivated and provided very professional care to prisoners with very complex and challenging needs.

HMP SEND

13. HMP Send is a closed training prison near Woking in Surrey. It holds adult women serving a full range of sentences up to and including life imprisonment. At the time of the woman's death it held up to 216 women. In February 2008, after extensive building work, a new 64-place residential unit opened. The residential accommodation consists of three parallel wings joined together by a main spine corridor known as main block, an addiction treatment unit, a therapeutic community and a resettlement unit. It is notable that Send is one of a handful of prisons that no longer has a segregation unit, and its use of force and reliance on adjudications (formal disciplinary hearings) are low.
14. Her Majesty's Chief Inspector of Prisons inspected Send in February 2006 and summarised Send's performance as impressive. Her inspection report described Send as a "safe, respectful and purposeful prison ... [where] women felt safe, levels of self-harm were low, [and] drug use was minimal ...". She said that there was little evidence of bullying, but "staff needed to ensure that such behaviour was not going unreported". Regarding self-harm and suicide, the inspection found that "women at risk of self-harm were generally well supported and given good care".
15. The most recent report by the prison's Independent Monitoring Board (IMB) dated April 2007-March 2008 says that a Measuring the Quality of Prison Life (MQPL) survey was conducted in September 2007. It found that 42 per cent of prisoners described Send as a "decent prison", which was lower than the percentage the year before. Whilst there were positive comments in the MQPL survey about the addiction treatment unit, the therapeutic community and offending behaviour courses, the most negative comments concerned the provision of healthcare.
16. The IMB report said that concerns it had expressed in its 2006-07 report about the shortage of nursing staff had deepened as the situation had deteriorated and was starting to have an adverse effect on the service provided to prisoners. It noted, however, that the local Primary Care Trust would be taking over responsibility for healthcare at Send in April 2008.
17. Regarding suicide prevention and self harm, the IMB praised "the caring and compassionate treatment of prisoners by staff, often when staff are under significant pressure". However, it was concerned that an audit in December 2007 had resulted in a "low" score, revealing some weaknesses to be rectified.
18. At the time of the woman's death, healthcare at Send was provided by the local Primary Care Trust (PCT). There was one part-time Community Psychiatric Nurse provided by the local NHS Trust and a psychiatrist for half a day a week.
19. Nursing staff provide a health service between 7.00am and 9.00pm approximately. There are no in-patient beds. A general practitioner is on call

for out of hours service. Officers can apply temporary dressings to prisoners' self inflicted injuries if nursing staff are unavailable, but prisoners are allowed to ask for dressings from a first aid kit to dress their own wounds.

20. The PCT commissioned a Healthcare Needs Assessment of the prisoners in Send in September 2006 to ensure that the PCT was commissioning services appropriate to the changing needs of the population. It found that "a significant proportion of inmates [44.5%] have a past or current history of drug use." In addition, the assessment found that the number of self harm monitoring forms initiated [F2052SHs] had risen from 10 in August 2004 to 25 in July 2006.
21. In response to 17 attempted suicides and overdoses using medication, a pilot scheme was set up to change the way medication was administered to prisoners. Nursing staff began issuing medication cell by cell, rather than requiring prisoners to queue in the healthcare centre. This reduced the number of overdoses to one in the following six months, as well as cutting non-compliance and bullying, and the pilot became standard practice.
22. The woman's death was the second of three apparently self-inflicted deaths that have occurred at Send since I took over responsibility in 2004 for investigating all deaths in prisons.

KEY EVENTS

The woman's previous periods in custody at HMP Bronzefield

23. The woman was remanded in custody in January 2005 after appearing at a magistrates court. She was taken to HMP Bronzefield. She was released on bail with conditions to reside in Approved Premises managed by the National Probation Service.
24. The woman was again remanded in custody from 14 October until 8 December for breaching her bail conditions. On reception, she was interviewed by a Nurse concerning her health history. The woman told him that she had suffered a nervous breakdown and had been treated in a psychiatric hospital but had been discharged in June. The woman disclosed that she drank a bottle and a half of wine and used heroin, methadone and crack cocaine every day. She was placed on a methadone and diazepam detoxification programme. Asked whether she had harmed herself before, she said that she had taken an overdose of aspirin in the past and that she felt like harming herself at that moment. The Reception Nurse described the woman as looking tearful and weighing just 34 kilograms. However, she was not referred to see a doctor. The woman was seen by a nurse on 2 November 2005 after reporting "seeing things which are not there" and saying that her head felt like it was going to explode. A fax received from her Community Psychiatric Nurse (CPN) at Eastbourne General Hospital gave her diagnosis as manic psychosis.
25. The woman spent a week on bail before being remanded in custody again in December 2005. She was interviewed by a nurse on reception. Her physical appearance was described as emaciated with scratches on both arms. She told the nurse that she had a number of health issues including problems with asthma and chest pain most of the time. She said that she had not used drugs in the previous month but a urine test gave a positive result for the presence of heroin and crack/cocaine. The woman said she was drinking half a litre of vodka a day. She was taking prescription drugs fluoxetine (for depression), zopiclone (for insomnia) and subutex (buprenorphine, a drug detoxification treatment). She admitted to harming herself by cutting her arms when last at Bronzefield and said she had harmed herself when not in prison by taking an overdose of paracetamol and aspirin in January. The woman was released from Bronzefield on bail once more on 5 January 2006 with conditions to live in Approved Premises.
26. In addition to the charges for which she had been remanded in custody, the woman had been arrested in January 2005 on suspicion of shoplifting. The police contacted a drug withdrawal worker after it was noticed that her son, who was with her, appeared to be experiencing drug withdrawal. The woman did not make any admissions but after some months she was charged with supplying her son with heroin and crack cocaine. The woman was remanded in custody in March 2006, charged with supplying drugs to a minor under the age of 16 and child cruelty. Her son, the victim, was taken into the care of social services.

27. When seen on reception at Bronzefield by a Nurse the woman was agitated and suffering from severe drug withdrawal symptoms. The woman said that she did not drink a lot, had never tried to harm herself and was not suicidal. Regarding her drug use, she said she had last used heroin, methadone and amphetamines three days previously, and was spending £30 a day on heroin and £10 - £20 a day on crack/cocaine. Her weight was recorded as 40 kg. The woman was placed on a methadone detoxification programme which was prescribed in diminishing doses until 27 March. On 13, 14 and 18 March she appeared to suffer from fits.
28. Authorisation was given for the woman's mail and telephone calls to be monitored for six months after concerns that she was contacting the media to discuss her offence and discussing it with her partner.
29. After discharge from the prison healthcare centre in March 2006, the woman was placed in a houseblock on normal location. She was advised not to discuss her offence with other prisoners, but told a Prisoner Custody Officer (PCO) that she had in fact told one prisoner whom she thought she could trust. Over the months, the woman incurred the displeasure of some prisoners on her spur after spreading unfounded rumours. These included that she had a famous boyfriend who sent her flowers, that she was having a relationship with a member of staff, and that she was pregnant as a result of the relationship. (Indeed, a court escorting officer wrote on the woman's Prisoner Escort Record to court on 26 May 2006 that she was two and a half months pregnant.) However, when she took prisoners into her confidence and they learned the real reason why she was in prison, they reacted negatively. She in turn experienced distress because of the collapse of the relationships.
30. On 16 March, the woman was assessed by a drugs Counselling Assessment Referral Advice Throughcare (CARATS) worker. The CARATS worker decided that a specialist drugs assessment was required due to the woman's past experiences of grief and suicide attempts. The woman was seen by a PCO on 20 April for a comprehensive substance misuse assessment. The woman told the PCO that daily drug use had been part of her life but that she was now drug free. She added that she was no longer in contact with her friends who were drug users but she felt depressed and had an appointment to see a psychologist. My investigator asked the PCO about his contact with the woman. He replied that the woman had given him what she thought were the "right" answers during the assessment, but she did not seem to apply any knowledge she had gained to her day to day life.
31. In June 2006, Bronzefield's security department first received information that other prisoners were becoming aware of the nature of the charges the woman was facing. The woman was placed in the Help and Direction Unit (HDU). (The HDU is a small unit with a higher staff ratio than usual. It accommodates up to ten women with physical, mental health, security or vulnerability issues which mean that it would not be appropriate to locate them in the main prison.) My investigator visited the HDU and discussed its purpose with

Bronzefield's Head of Healthcare. The Head of Healthcare described it as a halfway house between segregation, healthcare and living on a houseblock of 25 prisoners in the main prison, where the women could "step up or step down" depending on their needs. Rather than a permanent location for particular prisoners, the HDU is meant to be part of a healthcare process where a woman returns to a houseblock within six weeks. Due to the closure of the high security wing for women at HMP Durham, however, this has become more difficult.

32. The woman requested segregation for her own protection on 20 July following publication of her offence details in the press and being identified by other prisoners. A Security Information Report (SIR) submitted the same day by a Prison Custody Officer details that a prisoner read a newspaper report of the woman's case and passed the information on to other prisoners who began to shout out about her. Security Manager commented on the SIR that he had taken the decision not to remove the item from the newspaper because a missing article "would have raised suspicion anyway". The Senior Prisoner Custody Officer (SPCO) discussed the matter with the woman, who requested to move for her own protection. My investigator met with staff at Bronzefield who knew the woman well. In response to a question from my investigator concerning the removal of news items from publications, the Head of Healthcare replied that newspaper articles about prisoners were usually cut out before newspapers were given out. The SPC added that, despite staff efforts, prisoners could find out the information removed by telephoning friends or watching television.
33. A segregation safety algorithm was completed by a nurse (whose signature is partially illegible). (An algorithm is a flow-chart which asks standard questions to assess whether a prisoner is at risk if they are segregated.) The woman was assessed as fit for segregation as a Listener (a prisoner trained by the Samaritans to offer support to distressed prisoners) was available and she could use the direct telephone link to Samaritans.
34. On 27 July, the woman harmed herself by using a razor. She was allowed to use a razor for personal grooming provided she handed it back to an officer after she had finished with it. This appears to be the first recorded episode of deliberate self harm in her clinical record. She told a nurse (whose signature is illegible) that she was feeling very low in mood due to the press interest in her pending court proceedings. She said she had not been sleeping and was feeling suicidal. The nurse recommended that the woman should see a doctor and that there should be a review from the Community Mental Health In reach Team (CMIHT). The woman's F2052SH was reopened. The woman saw a doctor (whose signature is illegible in her clinical record) the next day. The doctor wrote that the woman was anxious and low in mood due to her court case. The woman did not express suicidal or deliberate self harm ideation. Medication to alleviate her symptoms was discussed and trazadone, an anti-depressant, was prescribed.
35. On 15 August, the woman asked to be placed in the Care and Separation Unit for the duration of her trial at court and in the period afterwards. (The Care

and Separation Unit is a small protected area where prisoners are held in single cells away from the main regime, usually as a punishment but sometimes for their own protection.)

36. The woman pleaded guilty to the five offences she was charged with, and in August 2006 she was sentenced to nine years imprisonment. She was upset and tearful so was taken to healthcare to spend one night after she arrived back from court. The woman asked for medication to calm herself down. She described her symptoms as feeling very anxious, low and was not sleeping. She had not been keen to take trazadone because it was causing her headaches. The doctor prescribed mirtazepine as a replacement.
37. A Prisoner Custody Officer told my investigator that, once sentenced, the woman's attitude changed. She was not expecting such a long sentence and she became "totally self absorbed" and self pitying. My investigator spoke to several members of staff who had known the woman. They agreed that the woman's behaviour had deteriorated the longer she spent on the HDU and that, in their opinion, she had exaggerated threats to her safety in order to stay there rather than go to a houseblock.
38. The woman requested segregation for her own protection on 11 September. It was granted, as the woman had been located on another houseblock and HDU previously after prisoners identified her. On 12 September, authorisation for the routine monitoring of the woman's mail and telephone calls was sanctioned by Head of Security in line with Prison Service policies regarding the safeguarding of children.
39. On 25 September, the woman told a Prison Custody Officer that, whilst she was in the meal servery, a prisoner who was in the SCU for a disciplinary hearing (an adjudication) asked her about her son in a "nasty" manner. The woman's period of segregation for her own protection was reviewed on 28 September and extended for another 14 days.

The woman's period in custody at HMP Send

The woman's first month at Send

40. In October 2006, the woman was transferred from Bronzefield to HMP Send. A Cell Sharing Risk Assessment was completed by an officer (poor quality photocopy, signature illegible) using the woman's Prisoner Escort Record (PER) and warrant for background information, on her arrival. The PER noted "PNC marker for R.T.C" (which meant there was a Police National Computer marker for risk to children). The form did not highlight the woman's history of suicide/ self harm, drug/alcohol use or that she could be vulnerable. In the section on risk, it (the woman's risk in sharing a cell was assessed as low but concern over the nature of her offence was highlighted. The woman was then seen by a Nursing Sister. She assessed the woman's risk to others as low and wrote that she was not aware of self-harm concerns at the time of interviewing her.

41. The woman was taken to the induction unit, C1, which is on the ground floor of C wing and has accommodation for twenty women in single cells. The upper floor of C wing, which also holds twenty women, functions as general accommodation. Induction for prisoners new to Send lasts for a week. Prisoners are then allocated employment or education and moved to another residential unit.
42. The woman was interviewed by an officer. At interview with my investigator, the Officer said that, apart from knowing that the woman had been segregated, she was not aware of her history at Bronzefield (as a high-profile prisoner) and that no special arrangements had been made for her arrival. She said that staff would normally keep an extra eye out for such prisoners, but they still had to start their induction on C1 before being moved elsewhere. The Officer described the woman as being very nervous because she was not used to being with so many other prisoners. Asked about the ways prisoners show their disapproval of others, the Officer said that it mainly took the form of name calling and shouting out of windows rather than physical confrontation.
43. On 7 October, the woman had an induction interview with an unnamed manager. According to the record of the interview, the woman said that she was not happy at Send and wanted to be transferred to a prison with a segregation unit. She said she felt very vulnerable due to her offence. It was explained to her that she needed to be part of a proper regime. The documentation ends, "very reluctant, almost scared. Said we would support her all we could". Information was given to staff from a prisoner that two prisoners had gone to the woman's door and told her that if she came out when their doors were unlocked she would "get her head kicked in". A second Officer submitted a Security Information Report (SIR) to the security department after the prisoner said she was concerned that the prisoners who wanted to know whether she had told staff that they threatened the woman. The woman wrote in her personal diary, "Here at Send, I feel really worried, I think I should put myself back [on] protection ... stay in my room for the next 3 ½ years. Please send me back to Bronzefield". On 8 October, another prisoner told the security manager that four named prisoners were planning to attack the woman with a mixture of sugar and water.
44. The woman remained locked in her cell for most of the day due to the threats she had experienced from some prisoners. These took the form of banging and kicking her cell door, shaking the handle, verbal abuse, liquid (which possibly was urine) being poured through a crack in her door and some faeces being pushed under the door. The Senior Officer (SO) placed a third Officer in the woman's cell for an hour in an effort to identify prisoners who were harassing and bullying her. Unfortunately, the officer was unable to identify particular voices due to the commotion. The SO spoke to five of the prisoners who were milling around the landing. None of them admitted seeing anything, but they said that the woman deserved to be harassed and she should be moved off the landing. The SO told them that the harassing behaviour towards the woman was unacceptable and they would not be allowed to dictate who should be located where. She added that, if it was found that any of them had been involved in the abuse, they would be

disciplined and possibly transferred out of Send. An investigation took place in accordance with anti-bullying policies in place at Send. All the prisoners identified as possible perpetrators were interviewed, warned personally about their future conduct, and received written notification that if the allegations were substantiated they could face sanctions.

45. As a newly received prisoner, the woman saw a doctor on 9 October. She disclosed a history of depression, drug abuse and 12 pregnancies, 10 of which had ended in miscarriage. She spoke about being given a hard time due to her offence and said she had been bullied over the weekend. She was not suicidal but anxious and suffering from lack of sleep. She agreed to take trazadone, the anti-depressant she had previously rejected at Bronzefield.
46. On 9 October, the woman completed an application form to join the substance abuse treatment programme. The woman completed a self test questionnaire which indicated that a positive answer to five or six questions would suggest a drug or drink problem. The woman answered "yes" to 23.
47. The Deputy Head of Healthcare described to my investigator the woman's demeanour at that time. She recalled during her medication round seeing the woman appearing distressed, sitting in the dark, huddled in a corner. She talked to the woman, who said she did not want to be at Send. The Deputy Head of Healthcare said that staff at Send would use anti-bullying procedures to challenge prisoners who intimidated others, and they would encourage vulnerable prisoners to face up to their difficulties and not to hide away. She added that it was difficult to get the woman to change her mindset as she had convinced herself that she would be bullied, even after some time had elapsed. The Deputy Head of Healthcare said she had tried to explain to the woman that hiding was counter productive but she would get angry and did not want to face reality.
48. As the woman was new to Send, she was interviewed on 16 October by one of Send's seconded probation officers. The probation officer recorded in the woman's Probation and After-Care Case Record that she had spoken to her without the benefit of seeing any previous documentation about her. The woman had said that, due to the negative reactions she had received from prisoners, she wanted to transfer to a prison in the north. She was keen to address her drug misuse and, after becoming distressed when talking about the deaths of her partner and daughter, wanted to be referred for counselling.
49. On 16 October, the woman did not turn up for a doctor's appointment to review her situation. A fourth Officer opened an F2052SH Self Harm at Risk form on 18 October after the woman told her that when she had tried to kill herself before, she felt so peaceful she wanted that feeling again. The woman told the officer that she could not go on with prison life and her head felt as if it was going to explode. The woman was placed on half hourly observation on F2052SH after showing distress due to "bullying issues and low mood". An hour later, the woman told a second Senior Officer that she was not feeling suicidal but was feeling down due to guilt about her offence and having a lot of things on her mind.

50. On 19 October, however, an unsigned entry in her clinical record reads:
“Tearful and depressed. Not wanting to take meds. Wanting to die but has not tried anything. Says she has had enough and wants to be left alone. No psychotic features. I am concerned about her and feel that she is very unwell. I also feel that she is at risk of harming herself and should be watched. She should see the psychiatrist and be assessed formally. She is refusing medication – both antidepressants and sleeping pills.”
51. The prison doctor conducted a case review on the morning of 19 October. He was concerned about the woman’s risk of self harm and decided that mental health nurses should undertake a constant watch. A nursing agency was contacted to provide suitably qualified staff. A Community Psychiatric Nurse (CPN) reviewed the woman’s situation. The only cell specifically designed to have as few ligature points as possible (a safer cell) was already in use, so the woman was observed using an ordinary cell.
52. On the same day, the woman was seen by the CPN employed by Surrey and Borders Partnership NHS Trust. The CPN did not find evidence of severe mental illness but thought there was evidence of personality issues and mild-moderate depression. The woman was unwilling to take anti-depressants and refused to discuss talking therapies or to see a psychiatrist. The CPN recommended that she should be placed under constant watch by a mental health nurse until the next morning when she could have a mental health assessment.
53. On 20 October, the woman had a mental health assessment. She said that she felt there was no hope as her former partner and daughter were dead and her son was in care, although she acknowledged that her parents visited her. The woman said that she was segregated completely in Bronzefield whereas she felt unsafe in Send and wanted to starve herself as she did not have “the guts” to hang herself. She agreed to try the anti-depressant, fluoxetine.
54. The Deputy Head of Healthcare submitted a “Manager’s report following an adverse incident” to the Primary Care Trust Clinical Governance Lead. She detailed her concerns about the lack of resources for vulnerable prisoners. There was only one safer, gated, cell which meant that, as it was in use, an ordinary cell had to be used. This increased the risk of harm because a normal cell afforded limited access at night for the mental health nurse carrying out the constant watch. Also, an ordinary cell had a bathroom attached which afforded the opportunity for the occupant to avoid observation if she wished. The Deputy Head of Healthcare outlined her concerns about officers being unable to staff the constant watch because it was seen as a healthcare matter for which the Primary Care Trust was financially responsible. The Primary Care Trust concluded that the woman’s healthcare was their responsibility as she was depressed and was taking mental health medication.

55. On 25 October, whilst on a constant watch, the woman made a superficial cut to her right arm during a changeover of staff. Asked by a fifth Officer what she had used to make the cut, she replied, "Anything I can get my hands on".
56. The woman remained on constant watch until 31 October. A case review attended by the CPN, a Principal Officer (PO), the Head of Healthcare, an agency nurse and the woman herself decided that she appeared to have made progress and her mood seemed to have lifted as a result of the anti-depressants she was taking. A support plan was put in place for her to be observed at half-hourly intervals during the day and hourly at night. Her meals would be brought to her room but the arrangement would be discussed at the next case review. She agreed to take a job in the stores department and asked to be placed on the waiting list to move to B wing.
57. Another case review took place on 2 November. A summary of the review said the woman found it "nerve wracking" to be back on the wing. She suffered two panic attacks the previous evening and felt this was because she had been expecting to see the psychiatrist to have her medication changed but (for unspecified reasons) this did not occur.

The woman's stay in the Addiction Therapy Unit

58. The woman's application to undergo a substance misuse programme was successful and she moved to the Addiction Therapy Unit (ATU) on 13 November 2006. The ATU at Send has been run by the Rehabilitation for Addicted Prisoners Trust (RAPt) since 2000. The aim of the intensive treatment programme is to encourage a move away from a lifestyle based around substance abuse and criminal activity. This is achieved by in-depth examination of issues in one's life using individual and group therapy, workshops and written assignments. Prisoners in the ATU are discouraged from contact with others for the duration of the programme.
59. A RAPt counsellor interviewed the woman on the day she moved to the ATU. The counsellor's summary of that meeting was that the woman "... appears to be in denial about her crime. She has a history of bi-polar depression and has been hospitalised three times (sectioned). She puts this down to the death of her partner and subsequent miscarriage. She does not want to let go of her feelings and move on. She says that she would not commit suicide now as her son would have to live with the feeling of being responsible."
60. In an exercise linked to addiction and denial, the woman was asked to write about five things she liked about herself. She wrote:

"I hate myself for what I have done, hate myself for the hurt I have given. But the things I do like! I know that before the drugs I was a really good mother with a very happy little boy. I liked myself for my hard work, I loved giving at work, I worry about other people if they're low, I like myself for being so strong, affectionate person when I get to know you."

61. The dining hall, where all meals are eaten, is a separate building away from the residential wings. To get there, prisoners walk along a long path which is staffed by an Operational Support Grade at a fixed point (where the angle of the route changes) and CCTV cameras. The Treatment Manager of the ATU, submitted a Security Information Report that a named prisoner (who was not an ATU resident) had sat at a table in the dining hall that was reserved only for ATU women, and tried to get information about the woman from those present. The women who were dining there told the Treatment Manager that they did not divulge anything but they had felt intimidated and did not want to ask the prisoner to leave. They also said that the officers present did not ask her to move away from the table. The report was considered by the Governor on 12 October. He asked staff to ensure that main block prisoners were kept away from ATU prisoners in the dining hall.
62. In the woman's first few weeks at Send, most of the prisoners were hostile but there were a couple who were friendly towards her. A particular prisoner knew the woman well. They had met in the HDU at Bronzefield and become friends. The prisoner told my investigator that the woman did not seem to be coping very well on the HDU. When the woman moved to Send a few months after the prisoner, she appeared to be more relaxed than at Bronzefield. She considered herself to be a bad mother and was thinking about what she had put her son through. The prisoner took the view that she did not want to be judgemental; the woman was ill at the time of her offending and needed to stop beating herself up about what had happened. The prisoner said that the woman suffered from depression, and publicity about her case did not help. Due to the high profile nature of her case, the woman could not keep herself to herself.
63. The woman started to go to the dining hall with the prisoner. Asked by my investigator about incidences of bullying, the prisoner said that she and another prisoner had acted as the woman's unofficial "bodyguards", one of them walking with her to the dining hall whilst the other walked a little way behind. Both she and the other prisoner faced harsh comments from other women who wanted to know why they were associating themselves with the woman. The prisoner described this as "indirect bullying". The woman would cry when this happened and feel low. When the woman felt very down, she would say that one day she would take her life. The prisoner did not believe the woman as she felt that there was a difference between self harm as a release or to feel pain and taking one's life. After a time, the woman lost the confidence to go out for her meals even though the prisoner offered to walk with her. Officers would collect the woman's meals from the dining hall and bring them to her room. Sometimes they would sit with her. Her moods would vary, in that one minute she would seem happy then she would go quiet. She would self harm by cutting herself and then suffer with other women trying to punish her by calling her a "nonce". The woman would try to build herself up but would become despondent when a prisoner made a comment to her along the lines of she should "rot". The prisoner described the woman as being a lonely person. She had a need to feel accepted but was unsure whether people really wanted to be her friends - and would question their friendship, including that of the prisoner. The prisoner's cell

was located above the woman's in the Therapeutic Community on the first floor of A wing, so to communicate when locked in their cells the prisoner would stamp on her floor and they would talk out of the window.

64. Another prisoner told my investigator that, when she spoke to the woman, she received a lot of verbal abuse from other prisoners. Along with a third prisoner (who was considerably older than most prisoners and regarded as a respected and influential mother-figure within the prisoner hierarchy), she took the woman under her wing.
65. The second prisoner likened the woman to "a little rabbit in the headlights of a car". The woman was scared of other prisoners and it was obvious she was being bullied. Although the woman would leave her cell, she never left the wing unless necessary. The second prisoner described an occasion when she took the woman to the dining hall and she was literally shaking. The second prisoner said she asked the woman to look around to see if others were staring at her. The woman admitted that they were not.
66. A fourth prisoner had known the woman from 2006 when they were in the same Approved Premises in Reading whilst on bail. They went to different prisons after being remanded in custody but met again at Send. The fourth prisoner said the woman had been known as "Twinkle toes" by the residents of the Approved Premises because she was immaculate, pretty, upbeat and wore footwear similar to tap dancing shoes. In contrast, at Send there was a marked change with the woman quiet and looking drawn.
67. Hailsham Community Mental Health Team faxed a risk assessment dated June 2005 to the CPN. Its summary of how the woman's state was:

"The woman presents as low in mood. She has poor self esteem and self worth. She is negative and bleak about the future. She feels unable to cope anymore ... she has no appetite or enjoyment in life. She wishes she were dead though does not feel suicidal and has no plan or intent."
68. On 16 November at 11.35 am, a review of the woman's F2052SH took place. The review summary said that the woman arrived in a positive mood. She said she was getting a lot of support from others in RAPt and her room mate so she no longer needed to be on an F2052SH. The review team agreed to close it. In the evening, however, the woman was found very distressed and crying. She reported to a sixth Officer that she was pushed against a wall from behind after leaving the Visits area by a prisoner she described as black and wearing a bandana. A seventh Officer interviewed the woman about her allegation. The woman could not identify the person concerned and did not want the investigation to be taken further because she was "asking for a transfer anyway." The sixth Officer re-opened the F2052SH at 8.00pm after the bullying incident came to light.
69. On 17 November, the Court of Appeal asked Send to provide information on the woman's conduct, and the effect imprisonment was having on her, for her upcoming appeal. The Nursing Sister provided a summary from the woman's

clinical record and her observed behaviour. She wrote that the woman, “has expressed suicidal ideations, has superficially self harmed, diagnosed with a personality disorder, the woman is concerned of the reaction of others in relation to her offence and avoids interaction with others, low in mood at time – not diagnosed as clinically depressed, still experiencing grief reaction, has never had any grief counselling, perhaps may benefit from counselling. Substance misuse is a dominant feature of her healthcare needs”.

70. In a memorandum to the court, an eighth Officer said that the woman feared attack from other prisoners and tended to stay in her cell when she was not working. She was living a solitary existence as it was difficult for her to establish friendships and prisoners associating with her were being subjected to peer pressure. The woman’s probation officer wrote that she had found it difficult to settle at Send but was motivated to address her drug addiction and seemed to be developing coping strategies. She also expressed concerns that the woman had tried to arrange to speak to her son, despite being aware that there were restrictions on contact, and that she minimised the effect her offences had on her son.
71. On 18 November, the woman managed to obtain a razor blade from an officer and harmed herself with it by scratching her right arm. The woman told her counsellor that she was feeling low because of the anniversaries of her partner’s and her daughter’s deaths. She admitted she had thought of hanging herself, but cutting herself had relieved the pressure instead. The counsellor managed to coax the woman into attending a group session within the ATU. An entry in the F2052SH by a ninth Officer said that the document was reviewed on 19 November and was closed. However, the record of case review is not attached to the F2052SH. Two days later, however, the woman again admitted to her counsellor that she had taken a razor and self harmed. She broke down and cried, saying that she was unable to cope with her feelings.
72. On the same day, after a ligature was found under her pillow, the woman discussed suicidal ideation with the Nursing Sister who described the woman’s mood in her clinical record as “extremely distressed and crying”. The Nursing Sister persuaded the woman to come out of the bathroom area of her cell where she had taken refuge. The woman told the nurse that, when she woke up in the morning, she banged her head on the wall in frustration that she still had not killed herself. The woman added that she just wanted to away from the pain she was feeling. The woman was placed on a constant watch, to be reviewed the next day. My investigator was unable to find details of when this ended or what support mechanisms were put in place to care for the woman.
73. On 22 November, the woman told the Deputy Head of Healthcare that she was feeling unsafe rather than suicidal, because the prison and the regime were different from Bronzefield.
74. On 23 November, a RAPt deselection meeting was held to discharge the woman formally from RAPt and refer her to CARATS. The Treatment

Manager of the ATU decided that the woman was unable to carry on with the treatment programme. It was too intense for her at that time, the ATU could not provide the close monitoring that the woman needed, and her self harming behaviour was affecting other clients in the unit. The Treatment Manager encouraged the woman to re-apply when she had sought help for her grief and was feeling more resilient. The woman said she understood why she had to leave the programme and wanted to return when she felt more stable. She did not want to return to the main residential block.

75. Later that day, the woman was heard in a telephone call with her father trying to obtain photographs of her son and arrange a telephone call with him. As a result, she was told by a Security Senior Officer that under Safeguarding Children procedures, social services and probation would need to be informed, and she would be banned from contacting the numbers she had been telephoning.
76. Telephone contact with her partner (who is not the father of her son) was also stopped although he was not informed of this at the time. Her partner later told my Family Liaison Officer that although the woman was barred from contacting him by telephone, no-one from Send discussed the reasons for this action at the time. Her partner said he and the woman found their inability to talk on the telephone very frustrating and stressful. Due to his disability and the travelling distance involved from his home to Send, he could only visit her once or twice a month. (Her partner wrote to Send in January 2007 to question why the bar had been put in place and asked how long it would last. Following a Public Protection meeting in February, it was decided that there did not appear to be evidence that the contents of his past telephone conversations with the woman had compromised her existing contact arrangements with her son. The Principal Officer wrote to the woman's partner on 2 March to inform him that the restrictions had been lifted.)
77. On the same day, a review of the woman's F2052SH took place. The woman refused to go back to C wing after her previous experiences and said she felt unsafe. Staff at the meeting expressed the view that the woman believed her situation was worse than it was in reality but the woman did not agree. The woman moved back to A wing.

The woman's return to A wing

78. The woman met with her CARATS worker on 28 November. They discussed ways she might deal with stress without resorting to self harm. The CPN told my investigator that the woman's name was mentioned to her a lot by staff who were concerned that she was struggling to adjust to Send after being in a protective environment at Bronzefield. Whilst the CPN met the woman several times during the course of F2052SH reviews, the woman initially resisted having formal sessions and displayed hostile body language to her. The CPN described her approach with clients as quite challenging and the woman did not like it. She pointed out that the woman was inconsistent in that she said she had problems attending the dining hall for fear of attack yet she associated with prisoners at other times. The woman's meals had been

brought to her cell when she first arrived at Send. The CPN tried to implement a graded exposure programme where the woman was encouraged to go to the dining hall for at least one meal a day, but then the woman would decide that she could not go to the dining hall. The woman would dismiss the nurse's suggestions or would deliberately do the opposite of what had been suggested. Nevertheless, the CPN began to see the woman on a weekly basis to actively encourage her to engage with the community around her. She said the woman displayed signs of a personality disorder although she was never formally diagnosed with such.

79. On 12 December, the woman completed a referral form to report a bullying incident. She wrote that, as she was returning to the main residential block from lunch, a named prisoner had spat at her. This made her feel "very scared and worried" about her safety. The prisoner was subsequently transferred to another prison because of her behaviour.
80. Intelligence gathered on 18 December 2006 suggested that the woman was being bullied by a named prisoner who was providing the woman with "protection" so that she would not face bullying from other prisoners. It was suggested that the woman was arranging for money to be sent to friends of the prisoner to get drugs sent in to the prison. On the same day, the woman received a letter from her son's social worker saying that, whilst her son was not ready for a visit or telephone call, he would like the woman to write to him.
81. During an F2052SH review on 28 December, the woman said she felt very vulnerable and wanted to go to a HDU. She was pleased that bullying was being investigated. The woman did not turn up for her appointment with her CARATS worker and was given a new appointment for 18 January.
82. A General Practitioner working at Send initiated an urgent mental health in-reach team referral on 5 January 2007. The woman told her that she felt high in the mornings and low in the evenings but self harm provided her with relief. The woman said that bullying was no longer a problem and that things were improving as her appeal against her sentence was coming up and she had contact with her son. The woman met with the visiting psychiatrist on 7 February.
83. Gradually, a few prisoners began to talk to the woman. She became part of a small circle who would gather to chat and socialise in the third prisoner's cell. They nicknamed themselves the "Black Hand Gang". In her police statement, a fifth prisoner said that when the woman first arrived at Send she was judged by other prisoners because of her offence. The fifth prisoner admitted that she was one of the women who had judged the woman and had been outside her door when she was locked in her cell, but she denied bullying her. She said other women had stood at the woman's door and called her a nonce or said that they would put a razor under her door and she should do herself a favour by slitting her throat. The fifth prisoner thought that the woman had faced such behaviour for about a month. After getting to know the woman and seeing how small and skinny she was, she apologised for her behaviour. She explained to the police that she had followed the behaviour of others and

acted in a way she should not have done. The fifth prisoner said that, when the woman first arrived, she had felt she could not go out because of possible bullying. However, her case soon became “old news” and the women moved on to calling another prisoner names. Regarding self harm, the fifth prisoner said that surprisingly, given the frequency with which the woman began to cut herself, she was quite squeamish and the cutting was not to kill herself, it was a pain release. She believed that a named prisoner was supplying the woman with medication which was being paid for by outside contacts in return for protection from other prisoners. She added that officers were very supportive towards the woman and her difficulties.

84. A sixth prisoner at Send, described the woman as quiet, “quite fretful like a little mouse ... like a scared little rabbit” and wary of people. The sixth prisoner said that she and others tried to encourage the woman to leave the wing for meals with them but she refused. She remembered the woman from Bronzefield but had not spoken to her then. The sixth prisoner admitted to the police that she too had judged the woman when she first met her, based on reports in the newspapers about her offence. Like the fifth prisoner, she had apologised to the woman for the way she had treated her and they began to talk to her after that. The sixth prisoner and the woman worked together in Send as cleaners. The sixth prisoner said the woman confided in her about her worries. The woman joked that the sixth prisoner was her bodyguard and the sixth prisoner was very defensive of the woman and looked out for her welfare. The woman told her she found it difficult to come to terms with the death of her partner ten years previously, her daughter and the loss of her son. The sixth prisoner described the woman as manic depressive. The woman spoke to her about self harm and suicide but the sixth prisoner took these to be passing comments. The woman had said to the sixth prisoner, “I won’t cut myself any more, but I will end up doing it.” The sixth prisoner did not ask her how she would “do it” as she did not think the woman was serious and the woman did not say.
85. A seventh prisoner at Send, said that she was aware through media reports of the woman’s case before she came to prison. She said she was not nasty to the woman but did not particularly like her and did not want to give her a chance so did not talk to her. However, when they were on the same wing, she decided to look at the woman with an open mind and started to speak. They became close and the seventh prisoner found the woman to be a nice person. The seventh prisoner heard from other prisoners that the woman had faced unpleasant behaviour from other women at first, such as urine being thrown through her door. As time wore on, however, people left the woman alone. Nevertheless, due to a fear of being judged and being scared of what people would say to her, the woman still would not leave the wing for her meals and they were delivered to her. The woman would lie on her bed with her door closed but the seventh prisoner would go into her cell and ask her what was wrong. The woman was wracked with guilt about her son, but would pretend that she was alright when, in the seventh prisoner’s opinion, she was not.

86. The woman did not talk to the seventh prisoner directly about suicide, but she would make comments like "I don't want to be here" and say that she could not cope with how she was feeling. The seventh prisoner said the woman had heard a conversation between some women, one of whom had said of the woman's self harm, "It's only for attention. She needs a slap or something". Another participant was said to have asked, "How would you feel if one day you found her hanging?" Asked by the police how it was known that the woman had overheard the conversation, the seventh prisoner replied that the conversation took place in the cell opposite the woman's and, given the proximity to her, it was assumed that she had heard. The seventh prisoner said that there were a lot of prisoners who disapproved of the woman's offence and, as a consequence, did not talk to her. Some people called her a "nonce" but nobody attacked her physically because it was known that other members of the "Black Hand Gang" were looking out for her.
87. A Governor interviewed the woman on 9 January 2007 about the bullying allegations received on 18 December. The woman said she was surprised and denied she was being bullied. The Governor wrote his summary report of the investigation that he was not entirely convinced and asked staff to remain vigilant.
88. During an F2052SH review on 11 January, the woman said that she felt "fine" and that her self harm was a coping strategy rather than a means to take her life. She said that she was not happy in Send as she wanted to be in a segregated environment and to move to HMP Styal in Cheshire where this was possible. A week later, her F2052SH was reviewed. The woman attended the review and said that everything was "fine" and she was not being bullied. Nevertheless, she did not like the atmosphere at Send and was not attending the dining hall. The F2052SH was closed. The woman did not keep her rearranged appointment with her CARATS worker that day. However, she made an application to join the Therapeutic Community (TC). (The TC is a national resource for women who are willing to explore their offending behaviour and problems through group therapy. They need to be motivated to change and lead crime and drug free lives on release.)
89. An F2052SH was opened on 23 January 2007 after the woman cut her left forearm with a razor blade. She said that she had done it to relieve stress as she had not harmed herself for several days and it helped her cope with prison life. On 26 January, the woman self harmed by cutting her right forearm twice. Her wounds were dressed by a Healthcare Nurse (HCN). The woman told her that she felt release from her anxieties when she cut herself although she felt silly afterwards.
90. The woman's F2052SH was reviewed on 1 February. The meeting was attended by her probation officer and the SO. The woman said that she was still anxious about going to the dining hall so she was not eating properly. The review team agreed that the woman should be observed three times during the morning, afternoon and evening until her next review on 8 February. The SO said he would make arrangements for her to be accompanied there to collect her meals, and the woman agreed to this.

91. The Court of Appeal reduced the woman's sentence by two years on 2 February. The woman told her father she was very disappointed by this as she had hoped the reduction would be more substantial.
92. The visiting mental health in-reach team psychiatrist, met with the woman on 7 February. Her clinical record shows that they discussed the pros and cons of her self harm cutting behaviour. She described the pain of cutting herself as "just punishment" and said that she deserved it. She found that planning and building up to cutting herself occupied her mind, the pain distracted her from thinking about other things, and attending to her wounds gave her something to do. She recognised the negatives of her self harm as: pain, feeling stupid, letting down friends, not being a long term solution and ruining her clothes. The woman accepted that she needed to take responsibility for her actions, but felt that her low mood was a barrier to her effectively working on her behaviour. She denied wanting to take her life but acknowledged that she was not deterred from cutting herself by the possibility that it might become lethal. The psychiatrist recommended that the woman's dose of fluoxetine should be increased (to help improve her mood so that she could engage in psychological work) and that she should continue taking chlorpromazine.
93. On 8 February, the woman's F2052SH was reviewed. The review was attended by the SO, two HCNs, an Officer and the woman. She appeared more positive in mood and said she was "feeling fine". She said that she had talked to the psychiatrist and her medication had been increased, which was assisting her mood. She added that she felt much better than she had in a long time. She still did not feel able to use the dining hall but she was making the effort to get out and about more. It was decided to close the F2052SH.
94. A further F2052SH was opened ten days later on 18 February by a second SO because staff were concerned that the woman was hoarding paracetamol. On page 1 of the document where the initiating member of staff reports their concerns, the second SO wrote: "Nursing staff were concerned about the number of paracetamol tablets the woman has been requesting. A search of the woman's room was carried out and staff found strips of bed sheet plus two bandages. I have concerns that these were to be used as a ligature".
95. The woman's actions were brought to the attention of the Head of Healthcare. She and the second SO asked the woman for an explanation. The F2052SH goes on, "She readily owned up to storing the tablets, stating that she had planned to take them on Tuesday following the release of [a named prisoner] who she has come to rely on for support. 46 tablets were taken from the woman. She did state that she didn't want to live ..." the woman said that she did not want to be on an F2052SH and refused the services of a Listener (a prisoner trained by the Samaritans to offer support to prisoners in distress). She told a third SO that she was feeling very low partly because her friends were leaving the wing she was on. She also felt that her medication did not work. The third SO arranged for the woman to be observed hourly.

96. The woman was reviewed on 22 February. The meeting was attended by the third SO, the HCN, a member of chaplaincy, an Officer, the probation officer and the woman. The woman said she was fine but still angry about her hoarded tablets being found. Her failure to make an effort to go to the dining hall was discussed and staff told her she was not helping herself in this regard. On 22 February, the CPN wrote a memorandum to the officers on the main block, asking for the woman's meals to be brought from the dining room for her for two weeks. In a written reply to the CPN on 26 February, the SO said that she had recently reviewed the woman's F2052SH and told her that she needed to start collecting her own meals. The SO said that, although the woman feared she would be picked on, "I have observed her on many occasions and prisoners are no longer interested in her or her crime. I believe the woman to be extremely manipulative over the situations of the meals ... I feel by bringing her meals up we will never achieve this as an establishment and never move her forward. The woman shows no distress or anxiety on the wing and appears to be in good spirits on association and during the working core day." The CPN responded on 27 February that, although the woman had not attended her appointment with her that day, the plan to address her anxiety to attend the dining hall would continue. The woman should collect her lunch and bring it back to the main block to eat, but officers should bring her evening meal until 8 March when the woman would obtain her own meals, "although consideration could be given as to when she attends, for example at the start of mealtimes if the dining hall is quieter".
97. On 1 March, another F2052SH review took place, attended by a fourth SO, the CPN, HCN, the woman's CARATS worker and the woman. The woman said that she had moved to a different cell, which had lifted her mood. She denied having thoughts of self harm and was finding her sessions with the CPN beneficial. The CPN said that the woman was now engaging well with her. The decision was taken to close the F2052SH.
98. Yet another F2052SH was opened by the fifth Officer on 4 March after the woman said she felt like harming herself due to the approaching anniversary of her daughter's death on 15 March. The woman told the fifth Officer and a member of the chaplaincy team that she was feeling suicidal and had poured Immac hair removal lotion into a cup to drink. A review took place on 8 March in which her mood was described as up and down. The fifth Officer wrote a reminder notice to staff about letting the woman have access to razors. It read "DO NOT issue the woman with a razor unless you can ensure it is only used for the allowed 20 minutes and then returned. Please ensure staff are aware during stores on Saturday mornings. She keeps getting hold of razors." The tenth Officer added "the woman has been getting razors from other prisoners".
99. On 15 March, the woman refused to attend the review of her F2052SH. Her cell door was seen to be shut when she had been previously warned by staff to keep it open. The fourth Senior Officer referred the woman to the Incentives and Earned Privileges (IEP) Board. IEP is a scheme for all prisoners which rewards good behaviour by offering incentives. There are three tiers - Basic, Standard and Enhanced. The woman attended the IEP

Board hearing on 23 March. The Board decided to downgrade the woman from Enhanced to Standard.

100. On the same day, the HCN wrote in the woman's clinical record that she had cut one of her fingers with a broken mug. Although the woman said that the injury to her finger was accidental, she admitted that she had cut herself deliberately on the arm with a piece of the mug.
101. The F2052SH system was replaced by the Assessment, Care in Custody Teamwork (ACCT) process in a rolling programme across the prison estate which began in 2005. This incorporated extensive training as ACCT requires a distinct shift in approach to managing and supporting prisoners at risk of self harm and suicide. The new procedures included having an interview with a trained assessor and being allocated a case manager. Send was one of the last prisons to adopt ACCT. On 26 March, the woman's F2052SH booklet was changed to a new ACCT Plan, which necessitated an assessment interview. Four markers were listed in the ACCT Plan as warning signs for the woman - low mood or irritation at unlock, hyperactivity, before and after visits, and if her cell door was closed or she was in another prisoner's cell with the door closed.
102. The woman was assessed by two Officers. The woman told them that she had feelings of stress, paranoia and panic. She was feeling guilt concerning her offence. She felt isolated once locked in her cell and it was at these times she was most likely to self harm. The officers suggested painting by numbers as an activity once she was in her cell. The woman described cutting herself as a means of release and not a suicide attempt. In the section of the ACCT plan entitled "Current suicidal thoughts and intentions", the officers wrote: "The woman does not want to be dead, but if things went horribly wrong in prison (the woman did not state what things) she has a plan to hang herself from her bathroom door or outside stairwell". After the assessment, a fifth SO, an eleventh Officer and the woman met. It was decided that the woman should be observed three times during each morning, afternoon and evening period, and hourly during the night. In addition, a member of staff should have a conversation with her during those periods. It was agreed that the woman was working hard with the CPN to address her mental health issues. As her risk of self harm was raised, her progress would be reviewed in a week's time and her CPN would be invited to attend.
103. A Caremap, a grid setting out individual strategies for supporting a prisoner and the goals to attain, was devised by the woman's care manager (the fifth SO). It identified four areas of risk when the woman was likely to self harm - if she was low in mood in the morning or at lock-up; if she was in another prisoner's cell with the door closed; if she was not sleeping properly; and if she did not have something to occupy her at lock-up.
104. My investigator asked the tenth Officer whether she had probed further when the woman said she would hang herself from the bathroom door or the stairwell. The tenth Officer said she had asked the woman to clarify what she meant. The tenth Officer suggested to the woman that she had mentioned

the stairwell because it was an unlikely place (it was external to the wing and in full view of the main path which runs down the middle of the prison) and she would be found quickly. The woman agreed that this was the case. The third SO, the Suicide Prevention Co-ordinator at the time of the woman's death, told my investigator that none of Send's residential accommodation could be regarded as safer cells (i.e. where points to attach ligatures had been eliminated as far as possible). A review of the apparently self inflicted deaths at Send after the woman's death had led to the bathroom doors being removed and replaced by a curtain. This action in itself, however, did not change cells into safer cells (which are designed to make the act of suicide or self harm by hanging as difficult as possible).

105. On 28 March, the woman asked a twelfth Officer if she could speak to one of the chaplains. When the officer said that she was not on duty, the woman burst into tears. Then she showed the twelfth Officer her right forearm which she had cut. The twelfth Officer's incident report said of the woman: "She clearly stated that she wanted to severely self harm, cause herself horrendous pain, hadn't gone as deep with cutting as she wanted, but that she didn't want to die. She described keeping herself awake with coffee all night so she could self harm, and showered to soften her skin up so it was easier to cut".
106. The same day, the woman attended an ACCT case review of her risk of self harm. The other participants were the fifth SO, a HCN and the Head of Healthcare. The CPN did not attend but was invited to the next review. The woman admitted that she had not tried to adhere to the Caremap but agreed that she would do so. Her risk was still assessed as raised.
107. At 2.40am on 30 March, the woman alerted a thirteenth Officer to the fact that she had self harmed by cutting herself with a drawing pin. Her cuts were cleaned and dressed.
108. The Nursing Sister wrote in the woman's clinical record on 1 April that she had numerous superficial scratches over both arms and her right leg.
109. An ACCT case review took place on 4 April. It was chaired by the SO and a visiting governor from a neighbouring prison, was present. The woman attended and said she was disappointed her CPN was not there. She said she was struggling with self harm, especially at night, and needed something to occupy herself as she slept during the day and was awake at night. Her Caremap was updated to encourage her to take some fresh air outside the wing and occupy her time.
110. In a letter addressed to the Duty Governor (received on 10 April) the woman's mother expressed her concern about the woman's health. She wrote:

"I cannot tell you how shocked I was by the change in the woman's appearance on my last visit. She has changed dramatically since leaving Bronzefield. I feel that she is like a different person. She is obviously depressed and seems to be no longer bothering with her appearance i.e. no make up etc. She cries on and off and says that she is petrified of the other

prisoners and what they will do to her. Her eyes you could see were swollen, puffy and red from constant crying. She appears to have lost all hope ... my biggest worry is her very depressed state. I hope you may be able to help me with this.”

111. My investigator asked the duty manager when the letter arrived what actions she took when she received it. The duty manager said she discussed it that day with the Head of Healthcare, who in turn asked the CPN to contact her regarding the woman’s mother’s concerns. The CPN responded that she did not have immediate concerns but she would email some feedback that could be used in a reply to the woman’s mother. The duty manager showed the woman’s ACCT case manager, the letter from the woman’s mother. The ACCT case manager said that he had seen the woman that morning. She had been working as a cleaner and had looked “well presented and seemed happy enough”. The duty manager asked him to ensure that an ACCT case review took place the next day and then spent some time examining the woman’s ACCT document. The duty manager said that she spoke to the woman’s probation officer regarding contact between the woman and her son. The probation officer responded that the woman had been told that she could write a letter to her son some time ago and that she could make an application to have a photograph of him which would be considered by Send’s public protection team. Finally, the duty manager wrote in the on-going record in the woman’s ACCT Plan that her mother had written about her concerns. However, healthcare did not perceive any immediate risk and an ACCT review would take place the next day.
112. The case review took place as scheduled on 11 April. The ACCT case manager, the probation officer, the CPN and the woman attended. A summary of the case review described the woman as being in good spirits. The summary did not refer to the letter Send had received from the woman’s mother. The woman said she would aim to use the Caremap. During the same review, her level of risk was reviewed and regarded as low. Her frequency of observation was reduced to once each morning, afternoon and evening, with observation three times a night rather than hourly. Her next review was scheduled for 25 April.
113. The woman saw the psychiatrist on 11 April. She told him that, although she had not cut herself for two days, she was cutting herself more frequently, could not sleep at night and had drunk hair removal lotion “but it didn’t do anything”. She admitted that she had been thinking about her daughter’s and her partner’s deaths and could not cope with her emotions, using self harm as a distraction. She agreed she would not self harm for at least 48 hours. She should let officers know if she felt she was going to harm herself or tell staff if she had harmed herself. The psychiatrist’s notes describe her as tearful at times, but showing good insight into her situation.
114. The woman’s partner visited her on 12 August. He described her demeanour to my investigator and Family Liaison Officer as “dopey ... as if she was heavily medicated”. She showed him cuts she had made around her wrists

(but concealed under her clothing) which he described as “severe.” Yet she was very chatty.

115. On 13 April, the duty manager forwarded the CPN’s feedback to the Head of Residence so that it could be included in the reply to the woman’s mother’s letter. The Head of Residence was on leave, however, and was unable to respond promptly.
116. The CPN met with the woman in the healthcare centre on 17 April at 10.30am. She described their last session to my investigator as having been good. She felt that the woman’s mood was starting to improve and her medication had been reduced. She did not think the woman’s risk had escalated. On her return from healthcare, the woman appeared to be in good spirits according to the tenth Officer. In the afternoon, however, the woman told the fourteenth Officer that her session with the CPN had been difficult as they had talked about her former partner and it was “new territory” for her. The fourteenth Officer observed the woman interacting with others during the evening. She was laughing in the third prisoner’s cell and told the officer she was okay.

The events in April

117. In April 2007, the woman mother received a letter from her daughter, dated 15 April. Her police statement describes her reaction: “She sounded in good form, so much better than I had seen her. The letter said that she had written to [her son] and this was great news for the woman. I was very relieved and told other family members about the lovely letter I had from the woman. I was so pleased for her.”
118. The woman’s cell was unlocked in the morning by the fourth SO. According to the entry in her ACCT Plan, the woman asked for painkillers and the nurse on duty checked to make sure she swallowed them. The woman’s prescription chart for medication issued was unsigned, although under “special sick” was written “18/4/7 parac 08.00 Tooth.” At the front of the chart was written “* 18.4.7 Hoarding meds”. It is not clear whether she was given any other medication that day. At 11:00am, the woman swore at a fifteenth Officer when he asked her to wear her red bib which identified her as a cleaner. The woman then said to the sixth prisoner that she would throw her television at him. The fifteenth Officer locked the woman back in her cell and, in the afternoon, she apologised for her behaviour. The woman was seen chatting with the third prisoner at various times during the afternoon.
119. The fourth prisoner told my investigator that the woman gave her a hug, started to cry on her shoulder and said she was being bullied. The woman said she could not take it any more so the fourth prisoner said try to be strong and not let the bullies get to her. It was the first time the woman had mentioned bullying, although the fourth prisoner was aware from other

prisoners that incidents had taken place. The fourth prisoner told my investigator that she had raised the topic with an officer in regard to the woman and been told they were dealing with it. The fourth prisoner had previously suggested to the woman to join her in the Therapeutic Community upstairs, but the woman had said she was not in the right frame of mind.

120. The prisoner said that she saw the woman some time between 6.30pm and 7.00pm. She said that the woman's eyes were red and she looked low. The prisoner asked the woman if anything was amiss but she replied no. The prisoner thought that perhaps she should say something to an officer but, when she passed the wing office, the woman was in it talking to an officer. Later, when she looked for the woman, another prisoner told her that she had gone somewhere with an officer so she thought that the woman was alright and left it at that.
121. The seventh prisoner told the police that the woman seemed no different from normal. She and the other "Black Hand Gang" members hugged and kissed goodnight as they usually did.
122. The sixth prisoner said she was one of the last prisoners on the wing to be locked in their cell that evening. She talked to the woman through the observation panel of the woman's cell door. She said that the woman seemed fine and was happy. The woman was wearing a baseball cap and smoking a cigarette. The woman kissed the glass on the panel and said, "I'll see you in the morning."
123. The prisoner stamped on her floor at about 9.30pm. The woman responded and they talked out of their windows for a couple of minutes about what was on television and if the woman was okay. The prisoner thought she heard a noise some time after 10.00pm and banged on the floor to get the woman's attention but there was no answer. She heard a person say "Shut up, up there," but it was not the woman.
124. In interview, the third prisoner was adamant that the woman said "goodbye" to her rather than "goodnight." She heard a chair bang in the woman's cell some time between 9.40 and 9.50pm. She thought the woman was smashing up her cell, or smashing a peanut butter jar so that she could have a sharp implement to cut herself with, and had thought, "Let her get on with it". The third prisoner said staff had in the main been supportive towards the woman, but she felt, as did the fifth prisoner, that on 17 April the CPN had delved down too deeply into the woman's emotions and she had been distraught after seeing her.

The discovery and aftermath of the woman's death

125. A night duty officer was one of five officers on night duty. Each officer had been placed in a different location in the prison every night during the seven day night shift. That night, he was on duty in the main block (which comprises A, B and C wings) with another officer. He told my investigator at interview that he counted the prisoners in A wing, accompanied by the evening officer.

He knocked on each cell observation hatch and checked that the right person was in the correct cell and that everyone was alright. The night duty officer completed a similar process on C wing and the Night Orderly Officer (NOO) covered B wing.

126. Whilst checking A wing, the night duty officer saw the woman at 8.50pm. He looked through the observation hatch in her cell door and saw her sitting on the floor in the bathroom doorway of her cell whereas she usually sat on her bed. He asked her if she was alright. She replied, whilst smoking a cigarette, that she was okay. She asked the night duty officer if he was still her personal officer as he had stopped working regularly on A wing. He told the woman that he was no longer her personal officer but he would check who would be taking over from him and let her know. He returned to the wing office and wrote in the woman's ACCT that he had spoken to her and she had replied that she was okay. The night duty officer was the last officer to see the woman alive.
127. The two night duty officers patrolled A, B and C wing landings alternately every half an hour and pressed a cell button at the end of each landing to confirm that a check had been made. At interview, the second night duty officer said that she would not look in cells whilst patrolling unless she heard anything or sensed that something was happening or was doing an ACCT check.
128. The second night duty officer said that, whilst patrolling at around 11.30pm, she opened the observation panel on the woman's cell door as she knew the woman was on an ACCT, but could not see her. She knocked on the woman's cell door and noticed that the bathroom light was on and the door open. She knocked twice more but there was no response. The second night duty officer was concerned that the woman did not reply so she radioed for the NOO to assist in entering the woman's room. She said it was not uncommon for prisoners on ACCT to hide around the corner of their cells or in the bathroom, but she did not want to go in by herself as she could not see what was happening. Using her radio, she asked the night duty officer to come with the self harm box (a box with first aid equipment to dress wounds), as she knew that the woman had a history of self harm. Whilst waiting for them to arrive, the second night duty officer continued to knock on the woman's door a few times but the woman still did not reply. The NOO arrived and they both went into the woman's cell.
129. The NOO went into the bathroom of the woman's cell and saw her hanging from her en suite bathroom door from a ligature made from a pillow case. The NOO lifted the woman up and the second night duty officer cut the ligature with a ligature cutting tool that she was carrying. The woman was placed on the floor. The night duty officer started Cardio Pulmonary Resuscitation (CPR), assisted by the NOO. The woman looked lifeless. Her lips and mouth were blue and purple, and there were no immediate signs of life.
130. The NOO left the woman's cell to call an ambulance as the gate area is not staffed at night and he was the only member of staff carrying keys. In

interview, he estimated he took five minutes to do this. He then returned to the woman's cell to continue CPR with the night duty officer. The ambulance arrived at 11.50pm. Paramedics were able to find the trace of a faint pulse after attempting resuscitation. The woman was accompanied to the local hospital by the two night duty officers. Cardiac output was lost in the ambulance en route to the hospital and, very sadly, the woman could not be resuscitated. She was pronounced dead at 34 minutes past midnight.

131. An envelope containing a card, and an upbeat letter to her son saying that she would write again, were found in the woman's cell after her death.
132. The woman's mother was told at her home of the loss of her daughter by the then acting Governor of Send accompanied by the second SO and a member of chaplaincy. The woman's father and partner were also told of her death.
133. A post mortem examination took place on 20 April 2007. The report described numerous old and more recent scars that appeared to be self inflicted wounds. The cause of death was recorded as hanging. Police enquiries did not find evidence of third party involvement.
134. A toxicological analysis of the woman's body fluids for the presence of alcohol, drugs and other substances took place on 25 April. The analysis detected zopiclone (a hypnotic medication for insomnia), fluoxetine and citalopram (anti-depressants), and caffeine in the woman's blood sample.
135. A report prepared by LGC Forensics described the presence of citalopram as "broadly consistent with therapeutic use" and did not attach significance to caffeine. However, the concentration of fluoxetine was described as being very high and "well within the range of values encountered in previous cases where death has been attributed to toxicity from overdose."
136. Regarding the presence of zopiclone, the report concluded, "... the concentration of zopiclone detected in the woman's blood is within the range associated with toxic symptoms."
137. My investigator asked a security analyst at Send how SIRs are processed. The security analyst said that staff are encouraged to deliver completed SIRs to the security office when it is open or to place them in a labelled large red box outside the office if it is closed. The box is emptied every day first thing in the morning and sometimes at lunch time if the office has closed.
138. On 20 April 2007 at 8.00am, an undated SIR completed by a HCN was found outside the Security Office with blank SIRs. The HCN wrote that the woman had been seen in her cell with medication in her mouth during the morning medication round. On the two occasions when interviews were scheduled at Send, the HCN did not feel she had sufficient time to prepare and the interviews did not take place. My investigator sent the HCN some written questions concerning the SIR. The HCN responded in written answers that she had issued the woman with the medication at her cell door during a medication round. The woman attempted to conceal the medication in her

mouth rather than swallow it. The HCN said she made sure the woman swallowed it. Asked if she could recall when that incident had taken place, she wrote "If security dealt with the SIR on the day that I submitted the form, then I have to assume it was the 20 April 07 that the incident took place." My investigator spoke to the HCN by telephone on 13 November 2008. Given that the woman had died in April, the HCN was asked whether she would reconsider her answer. The HCN replied that she could not recall the date as it was over a year before and she was used to completing lots of SIRs. She had checked EMIS, the electronic healthcare record-keeping system but there was no record of the date when the woman had attempted to conceal her medication.

Reflections from the woman's family and friends

139. The woman's mother said that the woman had struggled with being separated from her son and the knowledge that she would not be able to see him for years. The woman would always ask her mother about her son whenever they met and expressed her love for him. Her mother was aware that the woman harmed herself by cutting or scratching her arms. She described it as a release for the woman and it was not done for attention. She could only recall one occasion at Send when the woman had appeared to be considering or intending to harm herself. The woman told her that she had stockpiled paracetamol tablets which she had acquired by saying to nurses that she had a headache. The woman said she had intended to take the tablets because life was too hard. Her mother said that staff learned the woman was hoarding the tablets, however, and she handed them over when she was asked to do so.
140. Having thought about his last visit with the woman, a week before her death, the woman's partner described her behaviour as over tactile, which was unusual for her. At the end of their visit, she had hugged him warmly and whispered that she really loved him. He wondered, on reflection, whether she had already made up her mind to take her life. At the time, he had been worried about her behaviour but as he was due to visit her again the following week, he had thought it best to wait to see how she appeared then before deciding what to do.
141. The sixth prisoner, one of the prisoners who was on the same wing as the woman at the time of her death, and who has since been released, told the police that she had known the woman when they were both at Bronzefield and they had become friends at Send, where they both worked as cleaners. The sixth prisoner said the woman felt guilt over what she had done to her son and had previously said, "I can't do this any more". The evening before her death, the woman had been chatting in a cell with several other prisoners. The woman asked the sixth prisoner if she knew anyone who had hanged themselves. The woman's demeanour had been bubbly and happy. The sixth prisoner dismissed the woman's query as "crying wolf," because she herself had talked about taking her own life at Send.

142. The woman's prison world consisted of a small circle of friends who would mostly meet in the third prisoner's cell. In interview, the third prisoner said that she had noticed what were initial self harm scratches but the wounds had gradually become deeper. A couple of months previously, the woman had asked about hanging and the third prisoner had explained the physical effects on a body. The third prisoner referred to the woman hoarding paracetamol a couple of months before she died. The woman had told her and the third prisoner had passed the information to a nurse as she had alerted nursing staff previously if the woman had seemed off key. The third prisoner acknowledged that bullying occurred at Send and that the woman had suffered in the past. She told my investigator she would have confronted anyone who bullied the woman, and was adamant that the bullying that had occurred previously had stopped after she had taken the woman "under her wing". Other prisoners respected her status and, once she made it known that picking on the woman had to stop, then it was over.
143. The fourth prisoner concurred that bullying had been a strong feature of her own prison experience. She told my investigator that she had been verbally assaulted and intimidated at HMP Eastwood Park. On the day she arrived at Send, she had been punched in the eye by a prisoner who was swiftly transferred elsewhere. She was concerned that the people whom she perceived to have been the woman's bullies were still on A wing instead of being moved. They had attended her memorial service, and been crying. The fourth prisoner had spent nine months at Send but she still had fears about walking to the dining hall, although she tried to go there once or twice a week with other prisoners.
144. My investigator discussed bullying with Send's anti-bullying co-ordinator at the time of the woman's death. The co-ordinator said that the woman's case had been well publicised in newspapers, so even before her arrival at Send prisoners were well aware of who she was. My investigator asked whether pre-emptive measures were taken to protect a known vulnerable prisoner before her arrival. The co-ordinator replied that there were no set guidelines other than the standard procedures of appointing a personal officer and ensuring the prisoner knew how to report incidents to staff. Segregating someone immediately would make her stand out and might not be what that person wanted. The co-ordinator said that bullying (in the form of physical threats or comments) of prisoners convicted of an offence involving a child was common. She identified the walk to the dining room as one area that caused concern to vulnerable prisoners. Asked about her role, she said prisoner referral forms went into a "dip" in the main block office and would remain there until they could be investigated. She was based in the security department and did not actually see referrals until Wednesdays. There was no dedicated facility time for anti-bullying team staff, "so it is conceivable that a referral could have gone in and not actually been looked at, not even been read for days possibly, over a week." She described the task as "an uphill battle, we struggle".
145. My investigator discussed the woman's partner's concerns about access to razors, glass jars and other items that could be used for self harm with a

Governor. The Governor said that Send's policy was based on the Prison Service's policy for Suicide Prevention and Self-harm Management which points out that removal of a prisoner's personal items which could be used for self-harm could increase feelings of distress. Removal of personal belongings would only be considered as part of an ACCT case review and not as a matter of course.

146. Asked whether the woman had made progress during her time at Send her ACCT Case Manager felt that she had. On arrival at Send, the woman had just wanted to hide away, but towards the end she was cleaning the wing. Even though she had to be encouraged, it could be seen that there had been some improvement. The SO concurred that the woman had made limited progress. The woman looked smart when she was working and "always had a full face of make up on". She would do tasks, such as collecting her own hot drinking water, which staff had to undertake when she first arrived as she was too afraid to leave her cell. The second prisoner said the woman had moved on from the frightened rabbit stage to being more bubbly and outgoing. The CPN said that she had noted an improvement over the months she had been working with the woman. As part of their sessions, they would discuss suicidal ideation and intention. At interview, the CPN described the feedback she was getting from the woman: "Self harm was there but it was a habit and there was comfort from it but she was quite clear that there was no suicidal thoughts or intentions with it ... she was quite clear on various occasions that her intention wasn't to commit suicide and she had no plans ... there was nothing like that, there were no other kind of indicators, self harm hadn't got more impulsive or aggressive. There was nothing."

ISSUES

147. The woman was clearly a very troubled young woman. The exact circumstances surrounding the deaths of her former partner and her daughter are unclear, but her grief cast an indelible shadow over her life. She struggled with the pain of their loss and sank deeper into more entrenched drug use to the point where her day to day life was shaped around finding and taking drugs. The woman had a considerable history of drug misuse dating back over a decade. Her inability to address her addiction triggered the events which led to her imprisonment.
148. Although she had spent several periods on remand, she had not actually served a prison sentence before. Even the best run prisons with the most motivated staff can prove a challenging environment for a new prisoner.
149. The woman's mother spoke positively of the changes she saw in her daughter at Bronzefield. From an emaciated state and being under the influence of drugs, the woman underwent detoxification treatment to emerge more healthy and robust than before. She made friends, and it was only when they learnt details of her offences that she began to experience hostility.
150. The HDU, the small unit which afforded the woman some respite from hostile prisoners, was designed primarily as a healthcare resource rather than a unit for vulnerable prisoners. It was a temporary stop gap with the aim of returning prisoners eventually to normal location rather than being an end in itself. Catering for no more than ten prisoners, I can appreciate that the woman found it a sheltered and supportive environment, far removed from the bustle of Send's main block which accommodates up to 120 women. Bronzefield, the first private modern purpose-built women's prison, is fortunate in having such a resource and the woman clearly benefited from it.
151. The woman also spent time in the Care and Separation Unit at Bronzefield after being segregated for her own protection. Even there, she was confronted by a prisoner and asked about her son. This shows that segregation, whether self imposed or not, can only operate up to a point. It is a temporary measure. I can sympathise with the woman's mother who expressed concern that the woman had not been moved on to a prison where she felt more comfortable. However, the woman would not necessarily have been more settled at another prison and would still have had to make the same adjustments to her day to day life as she did at Send.
152. When the woman arrived at Send, she immediately said she wanted to be transferred to a prison with a segregation unit. It appears that she was unprepared for the realities of life outside the protective environment that Bronzefield's HDU and Care and Separation Unit provided. Whilst such units represent an ideal, women's prisons (unlike most male prisons which have dedicated wings for vulnerable prisoners) have pursued a policy of integrating women, regardless of their offences, as far as possible. Indeed, most women at Bronzefield are accommodated on ordinary houseblocks.

153. Given the extent of the woman's previous drug use, it is perhaps surprising that there is no evidence that she was taking illegal drugs whilst in prison. Three months elapsed when she was free of addictive behaviour. She was taking an anti-depressant which may have alleviated her mood. Her first recorded episode of self harm was at Bronzefield in July 2006 in response to publicity surrounding her offences. She acknowledged in her sessions with the CPN and the psychiatrist that her self harm had an addictive quality which enabled her to focus on the build up to and aftermath of cutting herself, stopping her thinking about other things.
154. The Addiction Treatment Unit (ATU) at Send was probably the closest in atmosphere to what the woman had experienced at Bronzefield. Unfortunately, the woman was not able to cope with the psychological rigour it demanded in tackling addictions by examining the reasons for offending. At the beginning of her short stay in the ATU, the woman began by minimising her responsibility for what she had done to her son. She then began to cut herself as she was unable to cope with the feelings awakened by looking at her past. The ATU might have provided the vehicle for the woman to rebuild her life. Unfortunately, she was unable to take advantage of it at that time but the opportunity to return was held open for her.
155. The woman feared being physically attacked due to her offences against her son. She reported that she had been spat at on one occasion and pushed by a prisoner on another. However, the woman also faced intimidation in other ways. She was called names, prisoners banged on her door and shouted abuse, and urine and faeces were pushed under her door. Other prisoners reported to staff what was happening. In an innovative move, the SO placed an officer inside the woman's cell in an effort to identify the culprits. Eventually, the suspected bullies were identified, interviewed and warned about their future conduct. This was followed up with a written warning to all concerned. This was good anti-bullying procedure. It showed to the woman and others that staff considered bullying a serious issue and were prepared to take robust action to stamp it out. The fourth prisoner, the woman's friend who had herself been the victim of similar behaviour, told my investigator that the perpetrators should have been transferred. I agree that transferring prisoners should be considered (and indeed was put into effect after the woman was spat at). However, each case needs to be considered on its merits rather than being subject to the imposition of a blanket approach.
156. Virtually all of the staff and prisoners to whom my investigator spoke at Bronzefield and Send acknowledged the presence of bullying. In the woman's case, it consisted not only of targeting her personally, but others such as the first and second prisoners who tried to be supportive of the woman were subject to verbal assault and pressured to stop talking to her. As it turned out, some of the prisoners who initially had been hostile to the woman eventually became friendly with her. Whilst bullying is a reality in most prisons, the "novelty" of a newly-arrived vulnerable or high profile prisoner in a women's prison loses its lustre over time. It is by no means inevitable that all women prisoners become persistent targets but preventing such abuse requires constant vigilance. The prolonged separation of

prisoners because of their notoriety is rare. The absence of a vulnerable prisoner unit or segregation unit at Send means that its prisoners have to develop practical strategies for conflict-resolution and co-existence (with others who may have breached the unwritten prisoner moral code) which transcend the initial crude threats and name-calling.

157. The significance of the journey to the dining hall as a focus for “acting out” what prisoners think of others is an important phenomenon. Send is one of the few prisons that serves meals in a separate building away from residential units. To get there, one has to walk through the grounds of the prison. At first, staff collected the woman’s meals but eventually she was encouraged to visit the dining hall escorted by a member of staff (and then with supportive prisoners providing unofficial escort). It seems the walk to the dining hall is a ritual that vulnerable prisoners dread but have to overcome. It is a rite of passage that has to be experienced and withstood. It would appear that the prisoners who take it upon themselves to shout abuse eventually lose interest and move on to the next victim.
158. However, in the woman’s case, she was unable to move to collecting her meals regularly. The CPN put in place a graduated exposure programme designed as a coping strategy for the woman to face her fear, but the woman could not persevere with it. When a breakthrough seemed likely, she decided that she did not want to go to the dining hall. The exchange of memoranda between the CPN and the SO shows the difficulties staff faced in deciding to what degree the woman should be moved from her comfort zone. When the woman went to the dining hall with the second prisoner, this was still not enough to encourage her to return, even though she acknowledged that no one was looking at her.
159. By remaining on the wing as much as possible, A wing staff felt that the woman was in fact drawing attention to herself. The description of the woman as looking like a timid, frightened rabbit caught in the headlights was one frequently repeated by prisoners. Combined with her slight physical frame, she enhanced her visibility to those wishing to target her. I am satisfied, however, that staff acted to protect the woman from harm and that intelligence received was used to identify and punish those who threatened her. Although the fourth prisoner said the woman had told her she was being bullied the day before she died, I have not found any other evidence to suggest that the woman had experienced bullying since December 2006.

I am concerned, however, that staff tasked with operating the anti-bullying strategy were not given allocated facility time and that referrals could remain unread for over a week. I am aware that the anti-bullying strategy has been broadened to a violence reduction strategy. Bullying is a pervasive part of prison life and causes real damage to those it affects directly and the prison community as a whole.

I recommend that the Governor appoints a safer custody team leader who has responsibility for violence reduction to enhance the level of work and raise its profile at Send.

160. In line with Safeguarding Children Child Contact Measures and Prison Service Order 4400 Prisoner Communications procedures, the woman's telephone calls and mail were monitored. The woman was heard in a telephone call to her father in November 2006, trying to obtain photographs and engineer unauthorised contact with her son. I have seen the documentation which details the content of the telephone call. I believe that it was appropriate for Send to restrict the woman's ability to make telephone calls to persons who had access to her son. I appreciate Send's desire to give child protection due prominence. However, there was no telephone evidence that the woman's partner had sought to assist her in circumventing the contact arrangements in force at that time. It is regrettable that Send took three months to restore telephone contact between the woman and her partner, given her vulnerability and that it was only done at her partner's instigation rather than Send's initiative. Whilst I have decided not to make a recommendation, I have written separately to the Governor of Send to remind staff that the correct procedures should be adhered to.
161. The woman's family and partner raised concerns about adequate risk assessments being carried out, and that the frequency of observation was not appropriate, when it was clear to them that the woman was regularly harming herself. From the woman's arrival at Send, with the exception of the odd few days, she was on an open F2052SH booklet and its successor, ACCT Plan, for the majority of her time. It was recognised that she was vulnerable to suicide and self harm. There were weekly or fortnightly reviews of her behaviour and her level of risk. The reviews were multidisciplinary, attended by officers who knew the woman, healthcare staff, chaplaincy and CARATS workers, amongst others. One case review was scheduled to take place on the date, written in the ACCT Plan, of the woman's daughter's death. It is unsurprising that she failed to turn up. It is also unfortunate that she was referred for IEP downgrading on that day.

I recommend that ACCT review dates are selected so that, where significant dates of anniversaries are known, they are avoided.

I recommend that, where significant dates or anniversaries are known, these flagged up to personal officers and included as triggers on an ACCT plan.

162. The last case review took place on 11 April 2007. The woman's frequency of observation was reduced from three times during each period of the morning, afternoon and evening, and every hour at night, to once every period during the day and three times during the night. Given that the woman presented as being in good spirits, that decision appears reasonable at first glance. However, Send had received a letter from the woman's mother the day before saying how shocked she was by the woman's physical decline and that she was very depressed. In this context, it is very surprising that the number of observations was reduced so significantly the next day. Every member of staff attending the review was aware of the contents of the letter the woman's mother had written. Yet the summary of the review does not mention the

letter and it is not clear whether it was discussed with the woman at the review.

I recommend that, where potentially significant information has been received concerning a prisoner on an open ACCT plan, it must be discussed at the next ACCT review. The summary of the review should reflect explicit consideration of that information.

163. Whilst prison staff may be familiar with the behaviour of those in their care, the concerns of family members should be given proper weighting. It is not possible to say whether hourly observation would have saved the woman but it would have increased the likelihood that she could have been found sooner.
164. Whilst I can understand that prisoners wanted to keep the woman's partner informed about the circumstances leading up to her death, he was given information that was wrong. It must have added to his distress to have been told that the woman should have been checked every two hours and staff had missed the last check, when this clearly was not true.
165. The measures that the duty governor that day, took in response to the letter from the woman's mother were reasonable and comprehensive. She consulted the Governor, Head of Healthcare, the CPN, ACCT Case Manager and probation officer before updating the woman's ACCT Plan. However, she left the task of sending a written response to the woman's mother with the Head of Residence who was on leave. This meant that the woman's mother did not receive a reply before her daughter's death.

I recommend that when Send is contacted by a prisoner's family with concerns about their well-being, the duty governor should reassure the family as soon possible that their concerns have been acted on.

CLINICAL REVIEW

166. A clinical incident review meeting to consider the woman's death took place on 20 July 2007. It was attended by the Quality and Clinical Governance Manager for Surrey PCT, the Risk Manager Surrey PCT, an In-reach Service Manager for Surrey Prisons Surrey and Borders Partnership Trust, the Prison Liaison Officer, and the Independent Psychiatrist, Consultant Forensic and Adult Psychiatrist, Clinical Director, Kent Forensic Psychiatry Service.
167. The meeting considered the documentation available about the woman and what learning might be drawn from her death. In considering whether her death could have been avoided, the panel felt that it "could not have been predicted at that time. She was considered low to medium risk of suicide but high risk of self harm. In the days prior to her death, [the woman] had demonstrated active engagement with the mental health team and appeared to be making positive progress.
168. The panel examined the question whether there was an opportunity to prevent future deaths in similar circumstances. It concluded, "Consistent mental health involvement in the ACCT process could assist in discriminating between risk of suicide and self-harm without suicidal intent. This is a challenging issue but combining team members' views might make the risk assessment and management more robust as the management of each entity is distinct".
169. An independent clinical review of the woman's healthcare history was carried out by Consultant Forensic Psychiatrist. In an overview of the woman's mental health, the Consultant Forensic Psychiatrist said that, once the woman had undergone detoxification treatment in prison, she engaged in self harm as a substitute for drugs: "In my view, this was most likely to meet the need to deal with unacceptable overwhelming emotions, previously met by the mind altering effects of illicit substances".
170. Her report went on: "Mental health services ... did not come to the view that she required diversion to a mental health hospital. The diagnosis formed in her case was of a personality disorder, illicit substance dependence, opiates and cocaine, but currently abstinent due to being in a protected environment (custody) and with mild depressive episodes. Her self harm was linked to her emotional instability and impulsivity as a consequence of her personality disorder ... Based on the observations in the records, it appears that she benefited little from this medication. [Fluoxetine, an antidepressant, Chlorpromazine, a major tranquiliser, and Zopiclone, a sleeping tablet] ... it appears that whilst EK was a chronic risk of self harm and suicide there was no indication that the risk had escalated on the occasion of the actual suicide. Her care and treatment would be comparable to that which is available in the community and it is not clear that there is any further action that could have been taken to prevent her sad and untimely death."

171. In considering whether the woman could have been managed in an external psychiatric facility rather than in prison, the Consultant Forensic Psychiatrist concluded that there was no indication that the woman needed to be transferred. However, the Consultant Forensic Psychiatrist added:

“In retrospect, this is something that possibly might have been considered, although this lady’s presentation in custody is not especially unusual. Her offence, however, is more unusual and may be indicative of deeper emotional distress and personality disorder ...”

172. The Consultant Forensic Psychiatrist noted that a psychiatric report was held in the offender management file and access to it would have been useful for the mental health in-reach team. She has made five recommendations, which I support:

I recommend HMP Send considers development of safer cells to minimise risk of ligatures and hanging.

I recommend that Mental Health In-reach Team for HMP Send includes psychology time.

I recommend that Mental Health In-reach attend all possible ACCT reviews on patients who are on CPA to inform risk assessment and management, particularly discriminating between deliberate self-harm and suicidality and to enrich multi-professional discussions.

I recommend that the Mental Health In-reach Team are allowed routine access to the offender management file to gather helpful information such as psychiatric reports, which are commonly prepared in cases where there is a mental health contact history, prior to offending.

I recommend that the Mental Health In-reach Team develop a standard request letter outlining their role and their responsibilities regarding confidentiality for requesting health records from the NHS.

173. The HCN did not make herself available for a recorded interview with my investigator when asked to do so in October and November 2007. However, she did respond promptly to written questions put to her in November 2008. She had written several entries in the woman’s clinical record about her self harming behaviour and had attended several of her F2052SH case reviews. The woman’s clinical record had brief reference to her “hoarding meds.” The HCN wrote in a Security Information Report around the time of the woman’s death that the woman had been seen with medication in her mouth but the value of that information is diminished because she cannot recall exactly when she wrote the Security Information Report.

I recommend that the HCN is reminded of the importance of completing timely Security Information Reports and communicating their contents to the relevant staff.

174. On 27 February 2007, a search of the woman's cell yielded two razor blades and 47 paracetamol tablets that she had hoarded. She told her mother that she could acquire the tablets by telling nurses she had a headache. A post mortem examination found toxic levels of zopiclone and fluoxetine, two medications the woman had been prescribed, in her blood. It is unclear how this was possible. The fifth prisoner alluded to the woman arranging externally for a prisoner to be paid in return for supplying her with medication.

I recommend Surrey PCT reviews the dispensing of medication to prevent hoarding.

175. The woman's partner and friends raised the issue of her last appointment with the CPN having left her distraught. The woman told the fourteenth Officer that it had been difficult because they had talked about her former partner. The fourteenth Officer noted her conversation in the ACCT plan so that staff would be aware. Whilst the prisoner thought the woman had looked low and her eyes were red that evening, the fourteenth Officer had not noticed anything amiss. It is not surprising that discussing bereavement would unleash strong feelings and emotions. Having regard to all the documentation I have seen about the woman, I consider that she had good support networks within and outside prison.
176. The woman's family and partner had kept in contact with her by telephone calls, visits and letters. They were supportive of her throughout her imprisonment. Information about her son was provided through a social worker. Despite the difficulties that the woman had encountered with bullying and facing up to her own sometimes overwhelming feelings of guilt, grief and loss, staff and prisoners were aware of her vulnerability and developed formal and informal methods of keeping her safe. She was cared for under procedures for prisoners at risk of suicide and self harm. She was receiving regular and appropriate mental health input from the CPN and the psychiatrist. Prisoners who had threatened to harm her were identified, monitored and moved. She rekindled friendships with prisoners she had met in Bronzefield, and she became part of a close-knit group of women in whose company she felt safe. The woman also had the opportunity to work on her addictive behaviour through the ATU and CARATS. It is very sad that she felt she could not leave the wing for fear of being attacked. No matter how unlikely this had become in practice, to her it was very real and no amount of encouragement could overcome her anxiety.

RECOMMENDATIONS

To the Governor of HMP Send

I recommend that the Governor appoints a safer custody team leader who has responsibility for violence reduction, to enhance the level of work and raise its profile at Send.

I recommend that ACCT review dates are selected so that where significant dates of anniversaries are known, they are avoided.

After consideration of the draft report, the Prison Service accepted the recommendation and responded: "The ACCT process is now in place – it allows flexible and individual risk management of prisoners and the case manager sets dates in a case review with the full involvement of the prisoner taking all relevant factors into account. Whilst for the woman this was appropriate, we should stress that avoidance only occurs when it is in the client's best interests – there may be occasions where an anniversary causes distress for a client and that individual desires a review meeting (which after all may be experienced as supportive).

I recommend that where significant dates are anniversaries are known, these are flagged up to personal officers and included as triggers on an ACCT plan.

The Prison Service has accepted this recommendation. After consideration of the draft report, it responded: "Triggers are initially identified at the Assessment stage, recorded on the inside cover of the ACCT plan and flagged up to staff using the observation books at relevant times including when there are significant dates or anniversaries. Triggers that are identified at earlier or later stages are likewise flagged and promulgated if required.

I recommend that where potentially significant information has been received concerning a prisoner on an open ACCT plan, it must be discussed at the next ACCT review. The summary of the review should reflect explicit consideration of that information.

The Prison Service has accepted this recommendation. After consideration of the draft report it responded: "Case managers are now aware of the review process being a flexible means of assimilating information and acting upon it to reduce risk. Training places special emphasis on making reference to the caremap at all reviews, enquiring about new information and acting upon it rather than just asking the prisoner how she is today. The recording of case reviews has improved considerably and management checks continually monitor this process.

I recommend that when Send is contacted by a prisoner's family with concerns about their well-being, the duty governor should reassure the family as soon as possible that their concerns have been acted on.

The Prison Service accepted this recommendation. After considering the draft report it responded: "HMP Send has a system whereby anyone contacting the prison with concerns about a prisoner will be referred to the orderly officer who must complete a form recording the details of the concern and what action they have taken to reduce any risk. If the concern is raised by the prisoner's family, they will be contacted by the duty manager to update them of any action taken.

I recommend HMP Send considers development of safer cells to minimise risk of ligatures and hanging.

To the Governor and PCT

I recommend that Mental Health In-reach Team for HMP Send includes psychology time.

Accepted. After considering the draft report, the Prison Service responded: "HMP Send now have psychology and psychotherapy time included in their mental health in-reach teams."

I recommend that Mental Health In-reach attend all possible ACCT reviews on patients who are on CPA to inform risk assessment and management, particularly discriminating between deliberate self-harm and suicidality and to enrich multi-professional discussions.

Accepted. After considering the draft report, the Prison Service responded: "Mental Health will attend all ACCT reviews on patients who are on CPA however we intend to move to a 'core team' system where riskier individuals are care managed by a group of staff including in-reach who best know that client. Attending reviews every time an incident happens with different officers present is not always helpful, especially in instances where this escalates the risks.

I recommend that the Mental Health In-reach Team is allowed routine access to the offender management file to gather helpful information such as psychiatric reports, which are commonly prepared in cases where there is a mental health contact history, prior to offending.

Partially accepted. After considering the draft report, the Prison Service responded: "Access will be determined by suitable arrangements for an appropriate IT system, or for high risk cases. We would not have resources that would allow us to check offender management files for every case referred.

I recommend that the Mental Health In-reach Team develop a standard request letter outlining their role and their responsibilities regarding confidentiality for requesting health records from the NHS.

Accepted. After considering the draft report the Prison Service responded: "Standard request letter will be introduced which outlines the role and responsibilities of the Mental in-reach team regarding confidentiality for requesting health records from the NHS."

I recommend that the HCN is reminded of the importance of completing timely Security Information Reports and communicating their contents to the relevant staff.

Partially accepted. After considering the draft report, the Prison Service responded: "I understand that this relates to a statement made by the woman that she was storing medication. It is important for healthcare staff to be reminded of the importance of considering submitting an SIR. However, it is more important to consider the clinical response when a risk like storing medication arises. There are confidentiality issues in passing on information and this has to be weighed up with the potential security/health concerns that the information raises.

I recommend Surrey PCT reviews the dispensing of medication to prevent hoarding.

Accepted. After considering the draft report, the Prison Service responded: "A thorough risk assessment is carried out on each of the female prisoners at Send before in-possession medication is given. Close liaison with discipline staff alerts us to potential problems, which will lead to cell search and to review of the risk assessment and method of administering medication. In-possession medication is not without risk, but there is a robust risk assessment and we should be striving to assist prisoners to accept responsibility for their own health so that they are better able to manage their health issues when discharged from prison. In-possession medication follows Department of Health guidelines.

GOOD PRACTICE

It was good and innovative practice to place an officer in the woman's cell in order to identify her bullies.