

**Investigation into the circumstances surrounding
the death of a woman, who was a prisoner at
HMP Eastwood Park, in October 2006**

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

March 2008

This is the report of my investigation into the death of woman on 8 October 2006 at HMP Eastwood Park. The woman was found hanging in her cell within a short time of having been placed in segregation.

I wish to offer my sincere condolences to the woman's family and friends for their loss.

The investigation was conducted on my behalf by two of my investigators. I would like to extend my thanks to the Governor and his staff at Eastwood Park for their help and co-operation.

In addition to my investigation, a clinical review was undertaken by the South Gloucestershire Primary Care Trust into the medical care that the woman received.

The woman was a repeat self-harmer who was also judged a threat to other prisoners and to staff. However, she also seems to have been unsettled by her time in the Therapeutic Community at HMP Send, and there was a failure to transfer information about her time there when she moved to Eastwood Park.

The woman had undergone a gender reassignment operation in 2004. At her death, she was 28 years old.

I do not criticise the decision to place the woman in segregation, given the perceived threat to other prisoners and staff. This was a professional judgement that was not unreasonable in the circumstances. However, it is a simple statement of fact that the woman seems to have taken her own life within a few hours of being segregated. The special risks attached to segregation, especially for those prisoners already identified as at risk of suicide and self-harm, have been a theme of all too many of my investigation reports.

I have made a number of recommendations in addition to those emanating from the clinical review panel.

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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SUMMARY

1. The woman had started life as a male and she underwent a gender reassignment operation in September 2004.
2. The woman was arrested in May 2005 for an offence of wounding with intent. She was sentenced at Plymouth Crown Court to four and a half years imprisonment on 22 September 2005. She was sent to HMP Eastwood Park.
3. During 2005, as her birthday and Christmas approached, the woman's mood began to drop and she was made subject to the ACCT (Assessment, Care in Custody and Teamwork) process to provide support over what, by her own admission, was a difficult time. (An ACCT is a document used to monitor and assist those prisoners considered to be at risk of suicide or self harm.)
4. Shortly after Christmas 2005, the woman was transferred to HMP Send. On 1 February 2006, she joined the Therapeutic Community (TC) there.
5. As part of the TC, the woman took part in group and one to one sessions exploring her experiences, feelings and situations, many of which were traumatic. She found the sessions challenging and began to self-harm and behave inappropriately (acting in a hostile manner and entering into a relationship with another TC member). She was placed on F2052SH documents (now replaced by the ACCT) a total of three times, representing most of her time at Send.
6. On 10 August 2006, the woman left the TC of her own accord before being voted off. She had broken a fundamental TC rule about not engaging in a relationship with another TC member. She asked to return to Eastwood Park.
7. The woman returned to Eastwood Park on 29 August. The open F2052SH was closed on 4 September, but an ACCT was opened on 15 September. Her mood had dropped and she had started to make threats towards staff and other prisoners. She also began to self-harm by cutting her arms.
8. Eventually, on 8 October 2006, the woman was segregated under rule 45 for reasons of Good Order or Discipline (GOOD). Staff were increasingly concerned by her behaviour and the threats she was making.
9. At about 4.45 pm that afternoon, staff saw the woman sitting on the floor of her cell against the privacy screen. When they investigated further, they discovered that she had tied a shoelace ligature around her neck and to the screen. Staff cut the ligature and together with healthcare staff they tried to revive her. At 5.30 pm, the woman was taken to a local hospital where she was pronounced dead at 6.03 pm.

THE INVESTIGATION PROCESS

10. An investigator from my office opened this investigation at Eastwood Park on 10 October 2006. The Governor and his staff produced the woman's core record and a number of other documents for examination. Notices were distributed around the establishment notifying staff and prisoners of the investigation. As part of the investigation process, a number of staff and prisoners were formally interviewed.
11. Her Majesty's Coroner was contacted to inform him of the nature and scope of my investigation and to request a copy of the post mortem report. Upon completion, this report will be sent to the Coroner to assist with his enquiries into the woman's death.
12. One of my Family Liaison Officers contacted the woman's family to inform them about my investigation and to offer them the opportunity to raise any concerns and questions that they would like explored and addressed. Both the Family Liaison Officer and investigator met with the woman's parents and her partner on 6 November 2006. My investigator summarised the progress of the investigation to date. The family raised a number of concerns in relation to the woman's care whilst in prison custody:
 - Why was the woman transferred from HMP Send to HMP Eastwood Park when she seemed to be getting on well there? Why was there ongoing uncertainty about where the woman would be placed?
 - Does the prison have any record of the call believed to have been made by the woman at 8:43pm on Thursday 5 October 2006? Could the woman have had access to a personal phone?
 - What was the content and nature of the letter found in the woman's cell?
 - Had the woman previously attempted to cut her wrists with a pen knife?
 - Could the woman's prescribed medication have caused any adverse reactions?
13. These concerns were explored by my investigator and are addressed within this report.

HMP/YOI EASTWOOD PARK

14. HMP/YOI Eastwood Park is a women's local prison for adults, young adults and girls under 18 years of age.
15. The most recent report on Eastwood Park by Ms Anne Owers, Her Majesty's Chief Inspector of Prisons, was published in June 2006. It reported on an unannounced short follow-up inspection to a full inspection in September 2003.
16. In her follow-up report, Ms Owers said: "The challenges facing Eastwood Park remain immense, and staff were hard pressed to ensure the safety of some very damaged and needy women. A number of areas and units were still bedding down when we visited, and it is to be hoped that by the time of the next full inspection significant further progress can be recorded."
17. Ms Owers said that, although Eastwood Park had implemented many of the previous recommendations relating to safety, rates of self-harm remained extremely high – averaging 65 incidents a week in 2005. Her report noted that relationships between staff and prisoners remained good.
18. In the 2003 inspection report Ms Owers said, "There was no segregation unit and the prison utilised special cells or the prisoner's own cell on the residential wings when segregation was necessary. While segregation was used relatively infrequently, the lack of a separate care and separation unit prevented the establishment from developing a cohesive management strategy. As we have recommended previously, Eastwood Park would benefit from a separate unit to care for, and help, disruptive, vulnerable and other women who were finding life on the wings difficult."
19. The report made the following recommendation to the Area Manager, 'There should be a care and separation unit to provide structured support to women prisoners who need to be held apart from the general population'.
20. In her follow-up unannounced inspection report in March 2006, Ms Owers commented on that recommendation stating, "Not achieved. There was no care and separation unit. The establishment had made a strategic decision not to introduce one, preferring to manage as many women as possible on the residential units..... "
21. Ms Owers made a further recommendation as follows, ' There should be a needs analysis to inform the strategy to deal with prisoners who have to be managed separately from the main population'.
22. The woman's death was the fourth of five deaths at Eastwood Park since April 2004, when I was given the responsibility of investigating all deaths in prison custody. The first two were from natural causes, and the third was accidental death caused by mixed drug toxicity. The most recent death (January 2007) was apparently self-inflicted death.

CLINICAL REVIEW

23. A clinical review of the woman's treatment in custody was undertaken by a panel consisting of the Clinical Governance Lead for South Gloucestershire PCT, a Modern Matron, HMP Eastwood Park, and the Assistant Director Clinical Governance, South Gloucestershire PCT. The Mental Health Service Manager for Avon and Wiltshire Partnership Trust helped to provide clarification of processes during the time the woman was at Eastwood Park and Send.
24. The panel made the following observations:
 - Appropriate Reception screening was undertaken with each prison transfer.
 - Full details of the woman's mental health history were in her records and referral to mental health services by primary care was both timely and appropriate. Difficulty with communication between the many services providing mental health care was addressed by having multi-disciplinary team meetings weekly. Membership included primary and secondary mental health care representatives, GP, CARAT staff (Counselling, Advice, Referral, Assessment and Throughcare) and others as appropriate. Minutes were recorded relating to each case discussed. The triage psychiatric nurse ensured that the ACCT process was in place.
 - All referrals between primary care and the mental health teams were acted upon. There were no referrals to other healthcare services. The woman was seen quickly following her referral to a psychiatrist by the primary care team. This was due to the availability of a visiting specialist registrar in psychiatry.
 - The woman was appropriately put on an ACCT. The level of self harming had not changed during the month prior to her death and the mental health services were involved. The GOOD [Good Order or Discipline] policy was actioned with safety in mind. There was uncertainty about the involvement of the psychiatric team when the GOOD was put in place (most likely because their services are not available at weekends).
 - The woman had been reviewed by a psychiatrist on three occasions within the previous year and was seen regularly by the psychiatric team. On all occasions, although there was a risk of self harming, there had been no suggestion of suicidal intent.
 - Following the woman's death two debriefing sessions were held within the prison to which prison staff and primary healthcare team staff were invited. The In-reach Mental Health team staff were not invited.
 - The panel also undertook examination of the medical records from Send. The investigation indicated that the approach undertaken by Send had been appropriate. However the therapy sessions had stirred up old memories which had resulted in a lowering of the woman's mood and behavioural changes. Regular observation had taken place and the psychiatric team had been used appropriately.

25. A number of concerns were raised by the panel concerning the standards of the medical documentation. These were:

- Many of the sheets within the record were not marked with an identifier
- A number of abbreviations had no explanation as to their meaning
- Records were not always dated
- Blank lines were not crossed through between entries
- The notes were not all filed in chronological order
- Some entries were illegible
- Not all screening information was complete or accurate
- The signature was rarely accompanied by the author's printed name.

The review team panel made the following recommendations:

- That there should be a review of the present record keeping within the prison in order to improve standards
- Where ACCT documentation is open, mental health and/or appropriate healthcare staff should be included in review meetings with outcomes recorded in the clinical record
- Unified electronic medical records with electronic messaging to aid communication should be introduced
- The contract for in-reach psychiatric services should be on a firmer footing
- The GOOD protocol should be reviewed involving the primary care and psychiatric services
- All staff involved with the person's care should be invited to the debriefing sessions and a significant event review.

26. The review panel commended the following good practice:

- The appropriateness of referral and actions taken by the primary care and mental health teams
- The clarity of the ACCT record.

27. A copy of the full clinical review is included in the annexes to this report.

WHAT THE INVESTIGATION HAS UNCOVERED

28. The woman was born as a male in December 1977 and underwent a gender reassignment operation in September 2004.
29. On 22 September 2005, the woman pleaded guilty to a charge of wounding with intent. She was sentenced to four and a half years imprisonment by Plymouth Crown Court and sent to HMP Eastwood Park. The Judge had the benefit of a psychiatric report which concluded:

‘There is no evidence that she [the woman] suffers from a functional mental illness such as schizophrenia. Her early childhood experiences and maladaptive behaviour patterns as a young adult make her vulnerable in times of stress to behave impulsively and to misuse substances to control her feelings. The features of nightmares, flash-backs, hyper-vigilance and ongoing low mood and anxiety would qualify for a diagnosis of a Post traumatic Stress Disorder. The woman is not suffering from a mental disorder of a nature or degree that would warrant treatment in hospital ... Factors that will increase the level of risk of harm to others are: Continuing substance misuse, including alcohol. Contact with her father. Difficulties in personal relationships.’
30. The psychiatric report was passed to the prison and included in the woman’s medical record.
31. Upon the woman’s arrival at Eastwood Park, a first reception health screen form was completed. The woman told the nurse that she was taking mirtazapine (an anti-depressant), oestrogen and omeprazole (a medicine used for gastric conditions) as prescribed medication. She also claimed to be suffering from memory blackouts. The woman told the nurse that she had not tried to harm herself in the past and that she had no current feelings that she might self harm. She did admit to feeling nervous as it was her first time in custody. The woman was referred to see the prison GP and the mental health team.
32. The woman was assessed as a medium risk prisoner because of the nature of her offence. She expressed concerns about sharing a cell because of her medical condition (gender reassignment) and was allocated a single cell.
33. The woman’s history sheet records that she was polite and completed her induction without problems. She was awarded enhanced status, which meant an increase in privileges over the standard regime.
34. The woman was seen by a registered mental health nurse, on 5 October. The woman said that she continued to have lapses in memory, but that she was able to function on the wing and work as an education orderly.
35. As her birthday and Christmas 2005 approached, the woman’s mood began to drop. She was given a written warning on 2 December for having an untidy cell.

36. The woman saw the mental health nurse again on 5 December. She told him that her anxiety level was increasing and she was experiencing symptoms similar to those before she committed her offence. She was prescribed carbamazepine to help with her black-outs and for its mood stabilising effect. She remained on her anti-depressant medication.
37. The woman was seen by the mental health team again on 9 December, as there was concern for her. She was distressed, anxious and perspiring. The woman said that she might have problems as it was her birthday the next day. She expressed no thoughts of self-harm. An entry was made in the wing observation book about the significance of the day for the woman.
38. On 11 December, there was a fight between the woman and another prisoner. It was believed to have started with verbal abuse towards the woman about her gender status. The woman sustained grazing to her knuckles after punching the wall. She received a lot of support from her peers for not fighting back. The woman reiterated that December was not a good month for her.
39. Over the next few days there was increased concern about the woman's lowering mood, resulting in an ACCT document being opened on 14 December. (ACCT stands for Assessment, Care in Custody and Teamwork. ACCT is a means for staff to provide individual care, support and monitoring for those prisoners who are in distress. It is used to help manage those prisoners who are at risk of suicide or self-harm.) In the woman's case, there were no suicide or self-harm concerns at that time. The ACCT document was opened to support her through the Christmas period.
40. On 16 December, it was noted in the ACCT document that the woman had been abusing her medication, not in an attempt to self-harm, but to get more effect from the drugs. It was decided that in future the woman would be issued the drugs on a daily basis.
41. Christmas and New Year passed without incident and on 3 January 2006, the ACCT document was closed. On 13 January 2006, the woman was transferred to HMP Send. She had said that she was happy to go as she knew people there.
42. The woman was seen on 29 January for a primary mental health assessment. No current risks were identified and it was noted that she was to enter the Therapeutic Community on 1 February. The Therapeutic Community (TC) is a wing within HMP Send which can accommodate 40 prisoners. It offers group based therapeutic treatment in a community setting. Prisoners lead and take part in twice-weekly community meetings where any problems affecting the community are aired and conflicts are solved in a democratic way. In smaller regular therapy groups the prisoners are urged to look into attitudes and feelings that trigger behaviour patterns. Their behaviour and attitudes are also open to question by their peer group.

43. On 16, 17 and 21 February, the woman took part in an initial therapy assessment in the TC. She appears to have been very open, giving information similar to what she had told the psychiatrist before her court case.
44. The woman told staff that she had concerns about her feelings of anger, saying that she was having dreams of mass murder. A new cell sharing risk assessment (CSRA) was drawn up, raising it to 'high'.
45. The woman was seen by a mental health nurse in healthcare on 24 February. The woman said that she had recently taken part in a life story session in the TC and felt that she might have disclosed too much. She also reported an increase in nightmares and memories during the day, and said that her anti-depressant medication was not helping. The TC psychologist wrote a security report the same day. The woman had said that she identified with the transsexual killer in the film *The Silence of the Lambs*, and watching it got her into a bad mood. The TC psychologist suggested that the woman should not have access to the film.
46. The TC psychologist opened a F2052SH document for the woman on 10 March. (The F2052SH predated ACCT to provide support and monitoring for prisoners at risk of harming themselves. It was still in use at Send at the time but has since been superseded by ACCT.) The TC psychologist opened the document after the woman had injured her hand by punching a door. She identified that the woman had just started therapy and that a lot of angry feelings were surfacing. The woman said that she was full of rage but that she was not going to harm or kill herself. She added that she was used to feeling rage, but normally controlled it.
47. The woman was regularly monitored and she continued to attend sessions within the TC. She said that the TC group helped her. There were no other incidents of self-harm and on 23 March it was decided, with the woman, to close the F2052SH.
48. On 7 April, The TC psychologist spoke to security staff concerned about the potential risk she felt that the woman posed. She said that the woman was behaving in a hostile manner and had said that the woman, 'is on the rampage'. The woman was spoken to by an officer on the TC and became calmer after being given some CDs from reception. The subsequent security report said that the woman's mood was very changeable and that she was a potential risk of violence to prisoners and staff. The decision was to monitor the situation closely.
49. The woman was seen by a nurse on 10 April. The woman admitted that she had not attended the dining hall over the past week, surviving on cigarettes and coffee. The nurse found that the woman was not suicidal. Nor was there evidence of psychosis, depression decline or any indication of violence to self or staff. The woman was asked if she wanted to see the GP, but she declined saying that she would not know what to say to him or what he could do. The nurse spoke to The TC psychologist the following day. She said that some

good work was being done in the TC and that the woman was probably frightened.

50. On 25 April, the TC psychologist noted in the woman's history sheet that the woman had felt much better during the previous two weeks. The woman had asked for her CSRA to be reduced so that she could 'buddy up'. The TC psychologist told the woman that she should talk regularly to her personal officer and that any reduction in her cell sharing risk assessment would depend on those reports and her feelings.
51. On 1 May, the woman's CRSA was reviewed but remained high. The next three weekly reviews on the woman were positive, remarking on how polite and well behaved she was. However, on 26 May, The TC psychologist opened another F2052SH. The woman had expressed a desire to self-harm. She said that she felt very low and found it an effort to socialise. The woman said that she was having flashbacks after attending a relapse prevention course. At her F2052SH review on 29 May, the woman said that she was finding it hard because therapy was helping her to connect with emotions and feelings that she had suppressed. It was decided that the woman should be encouraged to socialise within the TC and that staff would check on her three times a shift.
52. The woman appeared withdrawn at her review on 1 June. She said that it helped to know that 'staff would keep an eye on her at night'. The observation levels were maintained. The woman was also very quiet at the review a week later. She did say that she was in conflict with what was going on in her mind, and that she felt that she should be on the F2052SH. Observation levels were made hourly.
53. On 22 June, there was another review. The woman said that she had not been eating. She was asked if she felt that she could eat. The woman replied that slow starvation would be a better option than other forms of self-harm. She also said that she was feeling quite self destructive. A food refusal book was opened and the observation level was maintained at hourly intervals. Later that day there was a vote in the TC to decide if the woman should remain within the community. The woman had threatened to assault a member of staff some time before, although the threat only came to light on 7 June when another prisoner mentioned it during a session. In the end, the other members of the community voted for her to stay.
54. The woman saw a psychiatrist, on 26 June. He noted very similar information to that already recorded. The woman had been saying for a few weeks that the mirtazapine was not working for her. The psychiatrist prescribed clomipramine, an alternative anti-depressant.
55. At the review on 29 June, it was noted that the woman was glad not to have been voted off the community. She was now eating a little, with encouragement from her peers, although still not properly. The food refusal book remained open until 4 July. The woman said that she had feelings of losing control at times. The observation levels were reduced to three times a shift.

56. At the case review on 13 July, the woman said that she felt that she was coping better and that her mood had improved. She attributed the change to her new medication, making a friend on the TC and receiving a letter from a friend. The F2052SH was closed.
57. On 25 July, the woman's CSRA was reduced to medium. That meant that she was able to be a 'buddy' on the TC.
58. Unfortunately, she entered into a relationship with the friend she had made on the TC, which is contrary to the TC rules. The woman told the TC psychologist that sexual contact was followed briefly by a desire to kill. The woman was put back onto a high risk CSRA. The woman was told that, as a result of the relationship, she was to be the subject of another vote on the TC.
59. The TC psychologist opened another F2052SH on 31 July as the woman was unable to reassure her that she would not self-harm. The woman was worried about the impending vote.
60. On 3 August, the woman was taken to the neurophysiology department at the local hospital for an electroencephalogram (EEG). That is a test used to diagnose epilepsy. In the afternoon, the woman made multiple superficial cuts to her left forearm.
61. On 4 August, shortly before 10.00 am, the TC met to vote on whether the woman should remain. Part way through the meeting the woman walked out of the TC. The TC psychologist followed her and saw the woman head butting the wall violently. The woman said that it was either the wall or the TC psychologist. The vote did not go ahead.
62. The TC psychologist informed the wing staff that the woman was now back in her cell after head butting the wall. They went to her cell and found her with fresh cuts to her left arm. The woman started to punch the door. She was taken to healthcare where she refused treatment but cleaned her own wounds under supervision. Whilst in healthcare, the woman said that she wanted to move off the wing as she was feeling violent towards other TC members. She also said that she wanted to return to Eastwood Park, adding that she had only come to Send for the TC. Her F2052SH observation level was increased to every half an hour. By 11.15 am, the woman had calmed down and was well enough to attend work in the afternoon.
63. The woman was seen by the psychiatrist again on 7 August. The woman said that she was finding it difficult to cope and was confused. There was to be another vote on Friday 11 August. The woman denied having any suicidal or homicidal ideation. The psychiatrist wrote that, if the woman was voted off the TC, he believed that there would be an increased risk of self-harm. He increased the dosage of clomipramine and suggested that the woman remain in the TC as it would offer increased support.

64. The above information would have been available to all of the medical staff by reading the entry in the Medical record. For reasons of medical confidentiality it is unlikely that discipline staff were made aware of the details. There were no details recorded on her F2052SH.
65. The woman settled down over the next few days. She attended TC sessions without incident. On 9 August, the woman was given a razor, authorised by healthcare, for her to shave. It was to be returned 30 minutes later. The woman rang her cell bell after five minutes and handed the razor back. She said she would rather not have it in her room longer than necessary.
66. At 9.00 am on 10 August, the woman went to a TC group meeting and announced that she was leaving the TC. It was reported in her F2052SH that she found the announcement of her decision quite traumatic. At 11.20 am, staff answered her cell bell and saw that the woman had re-opened the cuts on her left arm. The woman did not want the member of staff to re-dress her arm. Later that afternoon, the woman agreed to go to healthcare where her arm was re-dressed. At her case review the woman told the panel that she had taken herself off the TC and was feeling very vulnerable and emotional about that. She requested that the observation levels remain at half hourly intervals. She also said that she wanted to return to Eastwood Park.
67. The following morning, the woman went to the TC. When she returned to her cell, she started packing her belongings. She told an officer that she was a little nervous about moving to C wing. She said that she was desperate to return to Eastwood Park where she felt her problems would subside. She also said that she enjoyed the more regimented and constructive routine at Eastwood Park. The woman moved onto C wing at 2.30 pm.
68. The woman officially ended her therapy on this day and a summary report was prepared by the TC psychologist and a colleague. The report makes the following recommendations:

‘the woman has expressed a desire to continue therapy on a one-to-one basis and at a later stage to come back to a Therapeutic Community, perhaps on release. I would support this and would like to emphasise that I feel that one-to-one psychotherapy is particularly important in her case in order to reduce the risk of her re-offending and hurting someone else. This should involve someone who is experienced as she has complex issues and concerns that need to be addressed. It will be important that as a higher risk offender the woman works closely with her allocated Offender Manager, to use the insights and change gained and to continue to work towards reducing her risk of harm to herself and others. In the opinion of the Therapeutic Community team her risk of harm remains high.’
69. The weekend passed without incident. During the morning of 14 August, the woman saw the psychiatrist again. He wrote that the woman would benefit from forensic psychotherapy which was not available at Send. He authorised a further increase to her medication and supported the observation levels for the

F2052SH. There is no evidence to suggest that an attempt was made to arrange psychotherapy.

70. The following afternoon, the woman told staff she believed that officers were not interested in her and that she was timing their visits to check on her. Staff were alerted to the fact that the woman was monitoring their visits.
71. The woman appeared to settle down well to life on C wing. On the afternoon of 17 August, the observation levels were reduced to every hour. At lunchtime the following day, the woman told the officer who was checking her that she had been playing with her old wounds. At lunchtime on 19 August, the observation levels were increased again to half hourly at the woman's request. She said that she felt the officers were not taking as much time with her on the hourly checks.
72. The next few days passed without incident. However, on 23 August, whilst at work in the stores, the woman showed her arms to staff saying that she had re-opened the wounds the previous night. The woman was taken to healthcare and her arms were re-dressed.
73. On 24 August, another F2052SH review was held. When the review began the woman was quiet and withdrawn, but became less so as it progressed. The woman admitted that she was still fighting thoughts of self-harm. She handed over a razor and suggested that staff should ask to see her arms when they observed her. The woman said that she self-harmed to save others, adding that she did not tell staff when she self-harmed.
74. The woman picked open an old wound on her arm during the night of 27 August.
75. At her case review during the afternoon of 28 August, the woman was withdrawn and quiet and told the panel that there was nothing wrong. She wanted the F2052SH closed. The woman appeared depressed but said she did not have thoughts of self-harm.
76. On 29 August, the woman was told that she was transferring back to Eastwood Park. The woman arrived in reception and said that she was happy to be going back as she had friends there and she would get more visits. She also told staff that she had left a razor hidden in a toilet roll in her room.
77. There was no prior discussion with the woman about the transfer, neither was it mentioned at her F2052SH case review the previous day.
78. The woman arrived back at Eastwood Park later on 29 August, saying that she was happy to be there and that she hoped to stay for the remainder of her sentence.
79. No reports were sent from Send with the woman detailing treatments and her experiences whilst on the TC. The resident psychologist at Eastwood Park did not receive the end of therapy report until 5 September. The TC psychologist

went on leave on 18 August and was on leave when the woman transferred back to Eastwood Park. She had not been aware of the move prior to taking her leave.

80. The woman was seen in the mental health triage on 31 August. She was referred to the visiting psychiatrist for assessment. There is an entry in the F2052SH that reports the woman as saying that she was a bit apprehensive due to not receiving her anti-depressants for three days. According to the prescription charts, the woman did not receive her nightly dose of clomipramine on 29, 30 and 31 August. She did receive this medication from 1 September. This particular medicine was not in stock at the Eastwood Park when the woman arrived.
81. A F2052SH review was held on 4 September. The panel recorded that the woman had settled very well back at Eastwood Park. She felt that problems she had experienced whilst at Send had been resolved. The woman was looking forward to employment and had no thoughts of self-harm. The panel and the woman agreed that the F2052SH should be closed. The panel could not know that due to an administrative error an attempt would be made to transfer the woman back to Send a few days later. Knowledge of a pending transfer might have altered their decision.
82. On 8 September, the woman was transferred back to Send but they refused to accept her as she had only been returned to Eastwood Park from Send the previous week. She arrived back at Eastwood Park the same day, a round trip of over 250 miles. When the TC psychologist was interviewed for this investigation, she said she had heard the paperwork was unsuitable and that was the reason the woman was refused.
83. On 11 September, there was a post closure review of the woman's F2052SH. The woman said that she found the transfer to Send and her return the same day unsettling. She also said that she had just been told that she would be transferring to HMP Foston Hall on 14 September. The woman was happy for the F2052SH to remain closed and had no thoughts of self-harm.
84. On 13 September, the prisoner with whom the woman had had a relationship at Send, and who was now also at Eastwood Park, voiced concern to staff about the woman. A security report was submitted. The prisoner claimed that the woman had stalked her at Send. The matter was investigated, but in the end no further action was taken as the woman was on a different wing.
85. On 14 September, the woman was told that her transfer to Foston Hall had been cancelled. The woman still had a high CSRA and Foston Hall only had dormitory accommodation available. The woman saw a visiting psychiatrist, that day. The diagnosis was that the woman had a personality disorder with emotionally unstable and dissocial traits. The visiting psychiatrist noted that in depth discussions about past sexual abuse should be avoided, but recommended regular meetings with the 'in reach' nurse to discuss current issues. The visiting psychiatrist did not wish to make any changes to the woman's medication at that stage, but wanted to review the situation in four to

six weeks. The woman handed back the appointment slip, saying that she expected to be moved to another prison in a few weeks' time.

86. On 15 September, the woman aggravated several old wounds on her arms with her nails. She said that she was getting highly agitated due to, as she saw it, a lack of concern or help from her psychiatrist. An ACCT was opened. The ACCT assessment interview with a psychology assistant shows how the woman's mood had changed in just a few days. She said that she did feel suicidal. She felt that she would harm or even kill somebody if she did not inflict pain on herself. The woman said that the therapy at Send had generated a lot of painful memories. Although she did not have a suicide plan, she believed that on a scale of one to ten the risk she presented to others was eight or nine.
87. During the assessment, the woman had said that the voices in her head told her to hurt the psychology assistant when her back was turned. The psychology assistant told the woman that not obeying those voices was a positive development. She later submitted a security report as she felt that the woman was a potential threat to staff.
88. The woman was referred to Stepping Stones, which is a day care unit within Eastwood Park where vulnerable women can receive education and take part in other activities such as art. She was also referred to see the resident psychologist at Eastwood Park.
89. A risk minimisation plan was drawn up and this was discussed with the woman by the resident psychologist on 20 September. The woman said that she thought the plan was fair and accurate regarding her needs. She recognised that she could pose a serious risk to others if she was not managed carefully. The woman also expressed concern about her treatment by the medical staff. She felt that she was not being listened to and that they thought she was only attempting to obtain medication. Her transfer situation was also discussed, although an officer spoke with the resident psychologist afterwards and said that there was likely to be difficulty arranging a transfer. This was because the woman was on an open ACCT and had a high CSRA.
90. On 25 September, the woman was told that she could go to Stepping Stones. She went that afternoon and appeared a lot happier when she came back onto the wing.
91. The woman raised no concerns during the day of 26 September, but around 10.00 pm that night she made cuts to her left arm with a razor. The wound was cleaned and dressed by healthcare. The woman handed staff the razor.
92. The woman went to Stepping Stones twice the following day and raised no concerns. However, she had a long conversation with a Healthcare Assistant. The woman said that she felt very low. She started to talk about her offence without being prompted, saying that she felt like a whole person whilst committing it. The woman said that she heard voices telling her to kill people and thought that she would act on them one day. She also said that she felt

dismissed and rejected by the medical profession, and might commit a serious offence to prove a point.

93. The woman was seen in the triage clinic on 29 September. She was very negative, complaining that people were being dismissive of her. She said that diazepam prescribed on 21 September was not working. She wondered if being violent would help as being nice did not. The woman made guarded threats of violence, but not towards any particular individual.
94. The resident psychologist saw the woman in Stepping Stones on 2 October. She noted that she was developing a friendship with another prisoner. (It is likely that the relationship started soon after the woman attended Stepping Stones for the first time.) The prisoner concerned was a young offender. The woman's risk minimisation plan highlighted the risk of her forming an inappropriate relationship.
95. Whilst in Stepping Stones that day, the woman and some of the other women were asked by the therapeutic art tutor to paint their ideal house. The art tutor was concerned by the underground house surrounded by barbed wire that the woman painted. It emerged during an interview with my investigators that the art tutor was not aware that the woman was on an open ACCT. In fact, she was not aware of the ACCT status of any of the prisoners with whom she worked. One of the Healthcare Assistants told my investigators that they got a list of the prisoners on an open ACCT every Monday, but that since the introduction of 'Freeflow' in the prison the ACCT documents themselves remained on the wings. (Freeflow is a system whereby the prison is opened for the prisoners to move around, taking themselves to education, work or other activities.)
96. During association on the evening of 2 October, some other prisoners were laughing, joking and making comments to the young offender whom the woman had befriended, saying that the woman was a man. The woman did not make any comment herself, and may not have heard. An officer was present and spoke to the woman afterwards. She said that she was alright but did not look very happy. The officer said that the comments were directed at the young offender rather than at the woman.
97. On 4 October, the young offender was moved onto another wing with a view to separating her from the woman. They still met up at Stepping Stones.
98. The woman's family say that she rang them and left a telephone message at 8.43 pm on 5 October. Unfortunately the message was erased. The prison has no record of that call being made officially, and my investigators did not find any evidence to link the woman with an illicit mobile telephone. At that time of night, the woman would have been locked in her cell.
99. The resident psychologist saw the woman briefly in Stepping Stones on 6 October. It was agreed that she would see her again on Monday 9 October. The resident psychologist later spoke to a Senior Officer and the OCA officer, about the woman's transfer. The OCA officer told her that she was still unable

to find a suitable place for her due to population pressures. (The OCA department (Observation, Classification and Allocation) deals with transfers and allocations to other prisons.)

100. That night at 10.40 pm, the woman was found to have cut her left arm again. The cuts were cleaned and dressed. The woman had a settled night after that.
101. At 6.30 pm on 7 October, a nurse was in a room on the wing talking to the woman. She made several threats to harm a prisoner or a member of staff. The woman said that she was very angry with the prison system which she believed had let her down. She said that she was not being taken seriously. She had decided that when the situation permitted, she would hurt someone without warning. The nurse was very intimidated and she was relieved when an officer came to the room.
102. The officer put in a security report at 7.00 pm after a prisoner found a screwdriver left by a workman. According to the prisoner, the woman had said that she would like to have been given the screwdriver so that she could attack an officer.
103. Officer R noted in the history sheet and in the ACCT that the woman's mental state and behaviour seemed quite odd that evening. When checking the woman as part of the ACCT procedure, the officer had found her pacing her cell in the dark. Officer R reported that the woman became quite angry when the officer put the light on.
104. On 8 October, as a result of the various threats made and the deterioration in her attitude towards staff, a resident governor decided to segregate the woman under Prison Rule 45 for reasons of good order or discipline (GOOD). This decision meant that the woman was confined to her cell and that three officers would need to be present to unlock the cell. The woman had been non-communicative with staff and just glared at them from her cell whenever they tried to interact.
105. Eastwood Park does not have a Care and Separation Unit where prisoners who need to be separated from the general population can be housed. The resident governor decided that the woman was already in the safest cell that was available to him, also taking into account that the Healthcare facility was closed.
106. The resident governor went to the woman's cell at 11.40 am and explained to her why he was placing her on GOOD and confining her to her cell. He gave her a copy of the form detailing the reasons for her segregation. She was uncommunicative. The resident governor explained to my investigators when he was interviewed that he had also spoken to the woman's ACCT manager (the Senior Officer), the wing staff and a nurse prior to making his decision. All were in agreement with the action. It was decided to keep the observation levels at three per hour.
107. At 3.15 pm, a Staff Nurse went into the woman's cell with two officers to give her medication. The nurse asked how she was and the woman replied,

'There's nothing wrong with me but I just don't know why I'm being locked up.' The Staff Nurse gave the woman her medication and the woman took it. She then said, 'I don't know why I've been locked up. I shouldn't have been locked up.'

108. At 4.00 pm, Officer G noted in the ACCT that the woman was non-communicative and sitting on the floor of her cell. At 4.40 pm, the woman was still on the floor in front of her bed with her head in her hands. When an officer spoke to her, the woman just turned her head to look at the officer. She did not speak.
109. At about 4.45 pm, another prisoner looked into the woman's cell. She had just collected her tea meal and had been asked by a young offender to say hello to the woman for her. The prisoner passed on the message to the woman who was sitting on the floor. The woman replied by sticking two fingers up at her. Another prisoner then looked in the cell. She told an officer who was nearby that she did not think the woman looked right. The officer looked into the woman's cell and saw her sitting on the floor leaning against the privacy screen.
110. The officer put the remaining prisoners back into their cells and then looked into the woman's cell again. She saw that the woman had not moved. She called Officer G to have a look. Officer G agreed that something was wrong and Officer Withers radioed for a Senior Officer to attend. As the woman was on a three officer unlock, another officer was called to assist. The Senior Officer arrived and opened the door, but it was partially obstructed by a chair. The chair was removed and the officers went into the cell. When interviewed one of officers said that it was 'only a matter of minutes' between her being told about the woman and entering the cell.
111. The officer called to the woman but got no reply. When she checked the woman's neck she could not see a ligature but then her colleague saw a thin shoelace tied to the privacy screen. He lifted the woman to relieve the pressure on her neck. One of the officers cut the ligature from the screen and then from around the woman's neck. The Senior Officer had radioed for healthcare to attend and then radioed a code blue (meaning that a person is not breathing). Staff started Cardio Pulmonary Resuscitation (CPR) and Healthcare staff arrived shortly afterwards and took over. The Senior Officer had already requested oxygen and a defibrillator. She then radioed for an ambulance to be called.
112. Three staff nurses responded to the call for assistance. One Staff Nurse checked but could not detect a pulse. Whilst the other two staff nurses continued CPR the other attached the defibrillator to the woman. The automatic machine advised 'no shock' and to continue CPR.
113. The paramedics arrived at about 5.20 pm and took over the CPR. They made a decision to transfer the woman to the local hospital at approximately 5.30 pm. Sadly, the woman was pronounced dead at the hospital at 6.03 pm.

114. The prison's death in custody contingency plan was implemented and various people including the police were notified. The duty governor at HMP Dartmoor was contacted with a view to him notifying the woman's mother and step-father in person. That was done at about 10.30 pm.
115. After the woman's death, some pieces of writing were found in her cell. The last pages were obviously written around the time she was segregated. The woman appeared to believe that there was a conspiracy against her. Her last written words were, 'Goodbye all those not in a plot against me!'

ISSUES CONSIDERED DURING THE INVESTIGATION

116. From the very early stages of the woman's period in custody, it was obvious that she would be a difficult prisoner to care for. My investigators found both at Eastwood Park and Send that the general standard of paperwork and the level of the care and concern shown by the staff was high. However, as with most of my investigations, certain areas have been highlighted that could be improved upon.
117. Prison Service Order (PSO) 2400 details the policy in relation to TCs. Section 3.6 states, 'Continuity, Aftercare and follow-up: An End of Therapy Report must be provided to the receiving prison and/or Probation Service on transfer of prisoners from a democratic TC. This will detail work completed and outstanding areas of risk/ targets for further work. An End of Therapy Case Conference will take place and receiving staff and other supportive individuals will be invited to attend either in person or by conference call.'
118. Whilst I acknowledge that the TC psychologist was on leave when the woman transferred back to Eastwood Park, I was concerned that a report from the Therapeutic Community did not accompany the woman.
119. The resident psychologist had to send emails and telephone Send to ascertain the circumstances under which the woman left the TC. It seems obvious from the written information and the staff interviews that the sessions whilst at the TC were traumatic for the woman. It was as if she was encouraged to open Pandora's box and then left with no means to close it. I do not believe that there was sufficient handover from the TC, to the wing and then to Eastwood Park. Some interviewees remarked that the woman was a changed person when she returned from Send.
120. **The Governor of Send, in co-operation with the PCT, should ensure that protocols are in place to provide proper continuity of care in compliance with Section 3.6 of PSO 2400 for prisoners leaving the Therapeutic Community.**
121. The woman was aware for a few days that there was to be a vote by the TC members to decide if she should stay. Such delay between being told there was to be a vote and the vote taking place has the potential to act as a trigger to exacerbate anxiety or self-harm.
122. Although the woman had asked to be transferred back to Eastwood Park some time before 29 August, I noted that there was no prior case review or discussion with her to help her prepare for the move as required by PSO 2700 when a prisoner is the subject of an F2052SH/ACCT.

4.3.4.3 The proposed transfer, and issues arising from it, must be discussed at a case review with the prisoner.

4.3.4.4 The prisoner should be given information about the regime and facilities of the new establishment, helped to prepare, and subject to

security considerations given the opportunity to contact family and friends prior to the transfer.

123. Since this report was issued in draft form PSO 2700 has been revised and the above is now covered in Annex 15b.
124. **The Governor at Send should remind staff of the need to comply with PSO 2700, Annex 15b, and consider whether any further training is required.**
125. When the woman returned to Eastwood Park, she was on a particular type and dosage of medication for her depression. It transpired that, as the drug was not in stock when she arrived, the woman did not get her medication for three nights. Healthcare staff have a responsibility to ensure continuity of medication for transferring prisoners, with the onus being on the 'sending' prison as set out in chapter 5 of PSO 3050.
126. **The Healthcare Managers and the PCTs at both Send and Eastwood Park should ensure compliance with the requirements of Chapter 5 of PSO 3050.**
127. On 8 September 2006, the woman was transferred back to Send. Send refused to admit her and she was returned to Eastwood Park the same day. As previously mentioned the round trip was over 250 miles and would have taken several hours. The woman found it unsettling. My investigators spoke with the OCA officers at both establishments. The woman was added to the transfer list as part of the normal re-allocation procedures to prevent overcrowding at Eastwood Park. On paper, the woman was suitable for transfer but due to an administrative error it was not realised that she had recently returned from Send. Upon her arrival at Send, the woman was refused admission as she had only left there the previous week at her own request.
128. **The Governor of Eastwood Park should consider whether any further procedures or training are required in relation to prisoner transfer arrangements.**
129. During the interviews with the art tutor and Healthcare Assistant, who both work in Stepping Stones, it became clear that ACCT documents were not accompanying prisoners as they moved around the prison following the introduction of the Freeflow system. The procedure adopted by the Stepping Stones staff was to go to the individual prisoner's wing and write in the ACCT document. That system introduces the greater potential for human error. It increases the likelihood that a member of staff who is not wing-based would be unaware that a prisoner was on an open ACCT. The ACCT document also very often contains information relevant to the safety of prisoners and/or staff.
130. **The Governor of Eastwood Park should put procedures and protocols in place to ensure that all staff are aware if prisoners are on an open ACCT.**
131. **The Governor of Eastwood Park should provide a means for the ACCT document to be readily available so that all staff can make timely entries.**

132. The decision to place the woman on GOOD and confine her to her cell on 8 October was not taken lightly by resident governor. Whilst the woman was still self-harming, her potential threat to others was also of growing concern. Prison Service Order 2700 says in Section 4,

‘Prisoners who are at risk of suicide or self-harm must not be routinely held in the segregation unit under Rule 45 GOOD (YOI Rule 49) unless, exceptionally, they are such a risk to themselves or others that no other suitable location is appropriate. Such prisoners must only be placed in a segregation unit in exceptional circumstances, or where all other options have been tried, but considered inappropriate and only where it is possible to provide the degree of continual care identified as necessary in the prisoners’ care plan. A case review must be held as soon as possible to take account of events leading up to the decision to segregate. If the decision is taken to locate prisoners at risk of self-harm within the segregation unit this must be for as short a period of time as possible, and the temporary nature of this must be reflected in the care plan.’

‘A mental health assessment must be undertaken by health care staff of all prisoners at risk of suicide or self-harm who are placed in a segregation unit, and the reviewed care plan implemented.’

133. Since this report was issued in draft form PSO 2700 has been revised and the above is now covered in Section 8.6.14 onwards.

134. The resident governor believed that to all intents and purposes he, the nurse and wing staff had held a case review that day but did not feel it right to bring the woman into a room full of people at that time. It was intended to hold a case review to which the woman would be invited the following day.

135. A mental health assessment was not undertaken when the woman was segregated. It should be noted however that she had been seen the previous evening by a mental health nurse who had also been consulted by resident governor prior to him making his decision to confine the woman to her cell.

136. **The Governor at Eastwood Park should remind staff of the need to comply with PSO 2700 Section 8.6.14 - 17, and consider whether any further training is required.**

137. The woman’s family asked at their meeting with my investigator and Family Liaison Officer whether the woman had previously attempted to cut her wrists with a penknife. There are several acts of self-harm noted in her medical record which were apparently inflicted with a razor. After the woman’s death, no penknife was found amongst her property. The family also questioned whether the woman’s prescribed medication might have caused any adverse reaction. The clinical review panel did not highlight any concerns regarding the medication and there are no negative interactions or relevant side effects listed in the British Medical Association guide.

138. The other matters raised during the family meeting have been covered in the narrative of this report.

RECOMMENDATIONS

HMP Send

- **The Governor in co-operation with the PCT should ensure that protocols are in place to provide proper continuity of care in compliance with Section 3.6 of PSO 2400 for prisoners leaving the Therapeutic Community.**
- **The Healthcare Managers and the PCT should ensure compliance with the requirements of PSO 3050, Chapter 5.**
- **The Governor should remind staff of the need to comply with PSO 2700 Annex 15b, and consider whether any further training is required.**

HMP Eastwood Park

- **The Healthcare Managers and the PCT should ensure compliance with the requirements of PSO 3050, Chapter 5.**
- **The Governor should consider whether any further procedures or training are required in relation to prisoner transfer arrangements.**
- **The Governor should put procedures and protocols in place to ensure that all staff are aware if prisoners are on an open ACCT.**
- **The Governor should provide a means for the ACCT document to be readily available so that all staff can make timely entries.**
- **The Governor at Eastwood Park should remind staff of the need to comply with PSO 2700 Section 8.6.14 - 17, and consider whether any further training is required.**

Clinical Review Recommendations

- **That there should be a review of the present record keeping within the prison in order to improve standards.**
- **Where ACCT documentation is open, mental health and/or appropriate healthcare staff should be included in review meetings with outcomes recorded in the clinical record.**
- **Unified electronic medical with electronic messaging to aid communication should be introduced.**
- **The contract for in-reach psychiatric services should be on a firmer footing.**
- **The GOOD protocol should be reviewed involving the primary care and psychiatric services.**

- **All staff involved with the person's care should be invited to the debriefing sessions and a significant event review.**