

The death of a woman in May 2004

**A report by the Prisons and Probation Ombudsman
for England and Wales**

April 2005

This is the report of an investigation into the death of a woman who died in May 2004 in a hospital in North London. The woman had been a prisoner at Holloway prison and the previous day had been found hanging from the window bars of her cell.

I offer my sincere condolences to the woman's family. Despite coping with her drug addiction in recent years, I know they always remained loyal, loving and supportive. I have great respect for the dignity they have shown.

I also offer my sympathies to management and staff at the prison. They have to work under difficult circumstances with large numbers of very vulnerable women who are remanded or recently sentenced, and in the great majority of cases withdrawing from drugs.

I am grateful to the Governor of Holloway for the help and hospitality received during the investigation. Every assistance was made available to my investigators and all staff co-operated fully and readily with the enquiry.

I appointed an investigator from my office.. A Senior Investigating Manager who works for the Prison Service London Area Manager, assisted us. His knowledge, commitment and hard work have been of immense value in expediting the investigation.

I am also grateful to the Detective Sergeant and the Detective Constable who, in carrying out their own enquiry into the woman's death, have shared all available information and given every assistance to my investigation team. Finally, I offer my thanks to Prison Service colleagues, for their help in conducting specific reviews and preparing reports.

The woman that died was a very vulnerable young woman. During her time in Holloway she displayed suicidal behaviours on at least 18 occasions. She lost the baby she was carrying. Within a few days, she herself was dead. This is a painfully sad story.

STEPHEN SHAW CBE
PRISONS AND PROBATION OMBUDSMAN

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Summary

This is the report of an investigation into the death of a woman in May 2004.

The woman was born in May 1975 in London. She died in May 2004, just two days before her 29th birthday.

The woman said that she had a history of substance misuse dating back to the age of eight, when she had started “sniffing glue”, which progressed to more serious drug misuse as she grew older.

The woman was arrested on charges of theft and burglary and remanded to HMP Holloway arriving on the evening of 1 March 2004. She was quickly identified as being at risk of self-harm and suicide and staff, both with the Court Escort Service and at Holloway took the appropriate action in opening an F2052SH booklet.

During the initial period of the woman’s custody, there were a number of incidents of self-harm and minor disciplinary problems. However by 20 April 2004, she appeared to have settled and was looking towards the future. On reception, the woman disclosed she was pregnant. She initially wanted to terminate the pregnancy, however she decided to keep her baby as the centre of her future. On 3 May 2004, the woman experienced pain in her stomach and was taken to Hospital where sadly she miscarried her baby.

The woman decided, against medical advice, to return to the prison on 5 May 2004. On her return, she was allocated to the induction unit, C3 and not to the pregnant women’s level, C4. This was with her agreement.

During the remainder of that day and the following day, the woman was seen by a number of the multi-disciplinary team including: Healthcare Staff, the Roman Catholic Chaplain and officers, to reassure her and offer help to deal with the situation.

Having acknowledged the input made by these individuals, it is difficult to understand why there appears to have been no attempt to co-ordinate these efforts. In line with the requirements of the F2052SH monitoring system, a full multi-disciplinary case

review should have been conducted, which would have included input from the woman herself. This did not happen, nor have the investigation team found any evidence to suggest that one was even considered.

The woman was managed on C3 level, initially on fifteen-minute observations and then later on thirty-minute observations. Following concerns of the Mental Health worker, and an attempted hanging on 6 May, she was relocated to dormitory accommodation in the hospital.

On the woman's arrival into the hospital, she was located into a single occupancy dormitory. Staff advised that there was no other suitable accommodation and that they felt no other people in the hospital were suitable to co-locate with her.

The woman was placed on hourly observation and was last seen approximately 30 minutes prior to being found hanging from a ligature attached to window bars. Staff immediately responded to the emergency situation and the appropriate contingency plans were activated.

There are a number of failures and issues identified in the investigation and subsequent specialist reviews. The report makes 25 recommendations.

Included as part 2 in this report, are four separate, but contributory reports:

1. **Management of the woman's F2052SH** by a doctor (PhD Forensic Psychology) – Suicide/Self-Injury Prevention Consultant, Women's Team, HM Prison Service.
2. **Review of clinical management of the woman's substance misuse** by the Nurse Consultant on Substance Misuse, Women's Team, HM Prison Service.
3. **Clinical Review of the woman's care during period of custody** by the Lead Consultant Psychiatrist in Substance Misuse (BMedSci, BM, BS, MRCPsych, DM, Section 12 Approved), , Camden & Islington Mental Health & Social Care Trust.
4. **Midwifery Officer's Clinical Review** by Suzanne Truttero, LSA Midwifery Officer.

Investigation Methodology

The investigation team met with Holloway Prison's Deputy Governor. They received a full and in-depth briefing on the incident, actions taken by the prison following the incident, the liaison with the woman's family and the contacts made with other relevant outside agencies.

The investigation team took possession of documentation relating to the woman's period in custody and was introduced to the team's Liaison Officer. Any request for additional documentation was provided without delay.

The team met with the Metropolitan Police Officers conducting their inquiry into the events to discuss areas of mutual concern and to agree protocols for co-operation. This was an extremely useful meeting and the liaison between Police and the investigation team has proved to be beneficial to both offices.

The team accompanied the Police Officers to the scene and were present whilst the Scenes of Crime Officer photographed and searched the area. Quantities of the woman's belongings were found in her room. However, the search failed to locate any note written by the woman to explain the action she took.

A meeting was arranged with the woman's mother and brother, at the offices of their Solicitors. At this meeting, the investigation procedure and the areas that the inquiry would cover were carefully explained. Members of the family were invited to raise any issues they wished the investigation team to address or to clarify. The family raised a number of issues, all of which were noted by the team. The meeting concluded with an undertaking by the investigation team to try to answer these issues during the investigative process.

Islington NHS Primary Care Trust (PCT) were contacted to request they undertake a clinical review, to determine the level of medical care received by the woman at HMP Holloway. Specifically, the PCT were asked to assess the issue of the woman's drug addiction, the decision to reduce her methadone and the issue of her pregnancy. They were asked to identify if there were any areas of concern that might be relevant to the investigation.

During a meeting held between the investigation team, the Clinical Reviewer and the Lead Consultant Psychiatrist, the investigation team's requests were discussed and a full copy of the woman's Prison Service medical records was supplied. In addition the Midwifery Officer conducted a review of the woman's maternity care, before and after the miscarriage.

The Nurse Consultant on Substance Misuse for the Prison Service Women's Team, was asked to carry out a review of the clinical management of the woman's substance misuse and to assess compliance against current Prison Service directives and Orders.

The Suicide and Self-Injury Prevention Consultant to the Prison Service Women's Team conducted a review of the woman's F2052SH documentation, and local procedures, to identify relevant issues or concerns.

On receipt the investigation team provided copies of the reports by the Nurse Consultant and the Suicide and Self Injury Consultant to the London Area Manager and Governor of Holloway for immediate action.

Background

The woman was born in May 1975 in London. Her prison records show her as being of Roman Catholic denomination. She died on in May 2004, just two days before her 29th birthday.

The woman told prison staff that she had a substance misuse history dating back to the age of eight when she had started 'glue sniffing'. This progressed to the use of cannabis at the age of nine and then on to the taking of Class A drugs (LSD) from the age of 13. The woman told prison staff that, at the age of 14, she left school, taking her educational examinations at a tutor centre. She continued taking a range of illicit substances until she arrived at Holloway on 2 March 2004.

The woman described her career history as Recruitment Consultant, Accounts Clerk, Hostess and Tabletop Dancer and she listed her interests as bingo, cinema and food.

The woman first came to the attention of police in February 1995. The woman's record shows 20 charges listed against her; 13 of these are convictions. The woman told staff at HMP Holloway that she had financed her substance misuse through shoplifting. For the majority of convictions she received both Community Rehabilitation Orders and Drug Treatment and Testing Orders.

This was not the woman's first custodial sentence, having previously served two short periods in prison. She was arrested by the Metropolitan Police for offences of theft and burglary. She was produced at the Magistrates Court in March 2004 and remanded to Holloway.

Whilst in police custody, the woman told the police that an unknown assailant had raped her, after she accepted a lift in a vehicle from him. She told the police that as a result of this she had become pregnant. The police were unable to investigate this allegation as she refused to make a formal complaint.

The investigation team met with the woman's mother and her brother . Although the team was unable to meet with any other member of her family, she had a sister ,who had been in contact with her recently.

HMP Holloway

Located in North London, Holloway is a women's local prison that serves the courts throughout the South East of England. At the end of March 2004, Holloway had a population of 460 female prisoners with 293 staff in post.

Originally a mid-19th century prison for men and women, Holloway became an all-female prison in the early 20th century. It was subsequently rebuilt in the 1970s and 1980s and designed as a secure hospital. Cells are located in a maze of corridors and spurs, which do not facilitate adequate observation of prisoners on the units.

Holloway is a prison with many diverse functions. Its main role is to hold women on remand or waiting sentence. It also has a Mother and Baby unit and a Young Offender unit that holds girls and young women between 15 and 21 years old. Many foreign national women awaiting deportation remain at Holloway following the end of their sentence.

The majority of women arriving at Holloway suffer from alcohol and/or drug problems requiring detoxification. Many are mothers with young children and up to 35% of the population at Holloway are foreign nationals. High numbers of the female prisoners suffer from mental health problems and many have poor literacy and numeracy skills.

Holloway has a very transient population with only one in four women still at the prison six weeks after their initial reception. In 2003/04, Holloway accepted 6,500 new prisoners.

Prior to the woman's death there had been two recent acts of serious self-harm within the prison, one of which had sadly resulted in the death of a young woman. In the other case, a young woman has sustained severe brain damage with an uncertain medical future. Before these incidents the last self-inflicted death at the prison was in August 2002.

Custodial History – HMP Holloway

Sequence of Events – Overview

The following is a brief timeline of the significant events of the woman's period in custody, her discovery and events at the hospital. These events will be covered in greater detail in the following sections of the report.

- 1 March 2004: Arrived at HMP Holloway. Placed on F2052SH.
- 2 March 2004: Cut left arm. Found with sheet tied to the window and demanding to speak with medical staff regarding the termination of her pregnancy.
- 4 March 2004: Stated that she wanted to kill herself.
- 22 March 2004: Cut left and right arms.
- 1 April 2004: The woman decided to continue with her pregnancy.
- 2 April 2004: Barricaded herself in room and observed making ligature.
- 9 April 2004: The woman signed disclaimer to reduce the medication levels of her methadone detoxification.
- 20 April 2004: F2052SH closed.
- 28 April 2004: Cut wrist. Second F2052SH opened.
- 3 May 2004: The woman was taken to Hospital. Baby believed to have died.
- 4 May 2004: The woman gave birth to stillborn child. Later the woman threatened to smash up her room and cut herself.
- 5 May 2004: The woman discharged herself from hospital and returned to HMP Holloway. Located C3 Unit and placed on half hourly observations.
- 6 May 2004: The woman was found sitting on windowsill with a ligature around her neck. Moved to C1 Unit (Healthcare) and placed on hourly observations.
- 7 May 2004: At 07.30 observed by day staff to be dressed and seated on her bed.
- 7 May 2004: At 08.13 The woman was discovered suspended by a ligature in her cell. Emergency procedures initiated and ambulance called.
- 7 May 2004: At 08.45 ambulance takes the woman to the Hospital.
- 8 May 2004: At 13.45 The woman is pronounced dead at the Hospital.

1 March 2004 – Reception

The woman was received into the custody of HMP Holloway on 1 March 2004, having been remanded by the Magistrates Court. When she arrived at the prison, documentation was received from the escort contractor advising that information had been received from the woman's solicitor, that she had in the past attempted suicide and that she had been under the care of the Psychiatric Department at a Hospital. Due to the nature of the information received, escort staff had raised a Suicide / Self-harm Warning form.

Having interviewed the woman, reception staff at the prison appropriately opened an F2052SH booklet – 'Self Harm at Risk Form'. The initial entry on page 1 of the document records, "Inmate is very upset, states she is withdrawing, is pregnant through rape and has harmed herself in the past." The entries say that the woman had stated, "She will attempt to harm her self." The woman was referred to medical staff working within the reception area.

In compliance with the prison's reception process, the woman was interviewed and a 'First Reception Health Screen' completed. This identified that she had a drug dependency and was currently on prescription from her Doctor for Methadone. The woman also stated that she had been taking Heroin, Crack Cocaine, Temazepam and Diazepam.

The woman informed staff that she had a history of psychosis and manic depression, that she had previously self-harmed by causing injuries to her left forearm, and had that she had taken an overdose in December 2003. When asked if she was taking medication for her mental illness she said that she was on a prescription of Chlorpromazine.

During the reception procedures, the woman underwent a drug-screening test. This test proved positive for the presence of Cocaine, Morphine, MTD, and Benzodiazepines. A further urine test also confirmed that she was pregnant.

The nurse who conducted the health screening recorded in the woman's's F2052SH, at 17:20 that same day, stated that the woman should be located into H1, dormitory accommodation and on a routine level of supervision.

The duty reception doctor examined the woman that evening and recorded her medical history in the prison Inmate Medical Record (IMR). This doctor also made an entry into her F2052SH at 17:45 stating: "Says will kill herself but did not express suicidal ideas. Wants more medication. Very angry." The doctor arranged for the woman to be located in the Detoxification unit.

Although the woman's computer record shows that she initially moved to Cell C3 –08, and then to H1 level at 02:30 on 2 March. However, this movement is not supported by any other documentation and is therefore believed to be inaccurate. It is the thought that she moved from the prison reception directly to H1 level. This is supported by her Detoxification Care Plan.

2 March 2004 – 2 May 2004

At 10:20 on 2 March 2004, an entry in the woman's F2052SH says that she was interviewed by a member of staff from the psychology department. The entry indicates that the woman did not feel well enough to speak with her at that that time. However, she did say that she felt suicidal and requested one-to-one support.

At 11:50 on 2 March 2004, an entry made in the woman's F2052SH notes that the Unit Manager saw her. This entry confirmed that she should remain in her present location and gave the reasons for this as: "[The woman] remains very angry at being in prison. Still claiming she was raped and is pregnant through this rape. Has contact with her family and boyfriend says he will finish with her if she doesn't have an abortion. Staff to observe closely during detox programme."

A further entry made by the Manager, in the support plan of the woman's F2052SH notes that she should: "Remain on F2052SH, Counselling reference rape, Keep in contact with family, Access to Probation, Access to Listeners¹ & Chaplaincy."

¹ A prisoner volunteer especially trained by the Samaritans to listen and support other prisoners who are in need or despair.

At 14:35, it is noted that the woman informed staff that she was feeling very suicidal. Staff subsequently recorded that they should: "Keep an eye on [the woman] for now." Later that same day the woman was found to have made superficial cuts to her wrists. In explanation she complained that the nurse had promised to speak to her.

An entry in the woman's IMR records a more detailed account of the incident stating: "[The woman] demanded to be moved out of her cell to discuss termination of pregnancy, which she did not talk about during association². She was talked to, reassured and seemed to understand why she could not be taken out of her cell. A few minutes later she started throwing chairs, swearing and cut her left arm. Officers on duty informed, they talked to her as well. On examination, superficial scratches seen, Betadine spray used. She was moved to a single cell. "The F2052SH records this as room 30 and it being "a safe cell".

Later that evening, staff reported in the F2052SH that the woman was found suspended by a bed sheet, tied to the cell window. They noted that the ligature was very loose and they easily removed it. A further entry records that she was now calm and she was given cake, chocolate, fruitcake and her medication, after which there were no further recorded incidents that night.

There were a number of further attempted and self-harm incidents recorded and these incidents are covered in the review of the woman's F2052SH management and medical care.

On 4 March 2004, the woman was seen by the prison doctor to discuss her wish to terminate her pregnancy. Following this, a referral was made to the Hospital and an appointment received for 23 March 2004.

Having been referred to the CARAT's (Counselling, Assessment, Referral, Advice, and Through-care) team on her initial reception, the woman was seen for assessment on 8 March 2004. A Care Plan was written and she was offered group sessions and identified as requiring further supervision and support.

² Prisoner's recreation period / time out of cell

On 18 March 2004 a member of the Outreach Mental Health Team (OMHT) met with the woman to conduct a Mental Health assessment. During this assessment she recorded in the woman's IMR: "Actively suicidal, hopelessness, no point in going on. Has been referred to **Henderson**. Imp Suicidal due to adverse situation – pregnant post rape, - TOP Monday (Termination of pregnancy), - withdrawing." The member of the OMHT wrote under the heading 'Plan': "Officers to be advised of suicide risk. , No reduction to Chlorpromazine, Regular OMHT review."

During 22 March, the woman was upset and said that she was unsure whether to continue with termination of the pregnancy. She attended her appointment the following day at the Hospital and subsequently returned to the prison later that morning.

The next entry made in the woman's IMR was dated 1 April and noted that she had now decided to continue with the pregnancy and was referred to the prison midwife.

On 2 April 2004, at 08:45 the woman was reported as, having "Lost her temper" and of having barricaded herself in her cell. She had physically thrown the cell television to the floor damaging it and had loosely tied a ligature around her neck. Staff entered the cell and moved her to A1 level, the Segregation Unit. The woman was charged under the disciplinary code for causing damage to the television and for preventing access to the cell.

The charge was heard the following day and the woman pleaded guilty. The Governor imposed 14 days loss of canteen facilities, suspended for one month and 14 days loss of earnings at seventy-five per cent. The woman became very upset during the hearing and remained in A1 level overnight. The following day she was relocated to C4 level, cell 19.

On entering the cell she informed staff that she might ask them to remove the television if she was tempted to "cut up", as she was concerned that she could use the glass in the television to harm herself.

On 5 April, the woman went to see the midwife and was observed to be upset when she came out of the room, complaining that prisoners located on C1, the level below

had been shouting all night and that this was driving her mad. She asked to be moved. However, staff told her that this was not possible, due to the lack of available cells. She then asked staff to remove the television from her room, which they did.

During the following days, the woman continued to complain about the noise coming from C1 level and made further requests for the removal of the television from her room. There were no incidents of self-harm or suicide attempts during this period.

The woman appeared to have settled into the routine of C4 level. Although she briefly experienced domestic problems with other prisoners on the level, these did not appear to be significant and were of the nature that one might expect when people live in close proximity to one another.

On 9 April 2004, the woman made a request to reduce her Methadone prescription. She signed a Detoxification Disclaimer and the reduction was agreed, at 2 milligrams per week. Although this form was signed on 9 April, the first reduction did not take place until 24 April.

The woman's improvement was noted during a self-harm case review held on 20 April 2004, and a decision was made to remove her from the monitoring system. Staff assured her that support remained available if she required it.

Although she was removed from the F2052SH system, staff noted that the woman was upset that evening. She explained to them that she had tried to call her family, but that they would not speak to her. Although she had been crying and was still upset she told staff that she was ok. Duty staff wrote in the observation book: "Says she's ok, but please observe". No further incidents or observations were recorded that evening.

During 24 and 26 April 2004, staff thought the woman had been acting suspiciously when approached, and staff received information that she might have been involved in illicit drugs within the level. Documentation was submitted to the Security department and notes made in the level observation books, advising other staff of these suspicions.

At 19:15 on 28 April, the woman made several lacerations to her left arm with an ashtray. A further F2052SH was raised and the level manager interviewed her. The woman explained that an officer had made comments regarding the scan of her baby, which had upset her. The woman said that she had “cut up because of the comments made by this officer”.

The woman went on to explain that she had also been upset, as she had not had contact with her mother and brother for sometime. The Manager identified a support plan for her and, after lengthy conversation, the woman said that she was fine.

Following this, the woman submitted a Request & Complaint form. This was answered by a Principal Officer who said that the officer concerned admitted making the comment, but had meant it only as a joke. The officer was unaware of the woman’s circumstances and extremely sorry. This explanation appears to have been accepted by the woman and there is no further reference to the complaint regarding this incident.

The following day, the woman was seen by medical staff who wrote in the F2052SH: “Not expressing any suicidal ideation, stated has no intention of killing herself. Worrying about her baby when born.” The healthcare worker noted that the woman was to stay on C4 level, in single accommodation, with regular observations.

The woman was seen by the prison doctor who wrote in the F2052SH: “Multiple superficial lacerations L. forearm. Been attended to already. Not suicidal and no intention to self harm any more, because of baby.” The doctor said that the woman should return to a residential unit. The woman continued to reside on C4 level. There were no further recorded incidents of self-harm.

The next significant event occurred at 17:25 on 30 April 2004, when the woman made a telephone call to her sister. Although not heard by staff at the time, the investigation team listened to a recording of the telephone call. During this telephone call, the woman asked her sister for the contact details of her brother. She also said, “I am going to end up hanging myself or something in here, I can’t cope, I have got no money, no clothes...” she repeated this threat twice. The woman made reference to being put back on suicide watch and repeated, “Well you know, don’t be surprised if

you find out I have hung myself in the middle of the night, yea.” she appeared extremely distressed during this conversation.

On 1 May 2004, the woman moved from her single cell, to dormitory 11. The following day, a Security Information Report was submitted, saying that the woman and a second prisoner had acted suspiciously when approached by a member of staff in the dormitory. The suggestion was that one of the prisoners had been trying to conceal something.

Miscarriage – 3 May 2004

On the morning of 3 May 2004, the woman reported to the unit staff that she was not feeling well. At 08:30 she collected her medication and was issued paracetamol, as she said she felt a bit “fluey”. At 09:30 the woman’s F2052SH records show that she had spoken to the midwife by telephone, as she had been experiencing pain in her stomach. The midwife recommended that she be taken to outside hospital. The woman was collected at 10:30, left the prison at 11:15, and was taken directly to the Hospital.

At 12:00 the woman was examined by a doctor, then admitted to the hospital. Later the woman was told that she was in labour and that due to the premature birth, they were certain that the baby would not survive.

At 20:20 a nurse and midwife told the woman that the baby did not have a heartbeat. The nurse said that if the woman had not started to deliver the baby soon, she would be given medication to start the process. The woman was extremely upset and asked the escort staff if she could return to the prison. This of course was not possible.

At midnight, the woman delivered the baby, which was confirmed stillborn. She returned to her room ten minutes later, and was allowed to speak to her sister on the telephone. The prison staff described her mood as angry and confused. At one stage, the hospital nursing staff asked the woman to calm her attitude and behaviour. The woman complied with this request.

Over the following days, unsurprisingly the woman is reported to have been very emotional and demanding of the prison staff. They facilitated regular smoke breaks off

the ward, and it appears that she sometimes became confrontational, trying to negotiate when these breaks should be facilitated.

5 May 2004 – Return to HMP Holloway.

On 5 May 2004, a hospital doctor saw the woman but against medical advice she decided to return to the prison. At 11.00 she signed a discharge notice and returned to Holloway. It is recorded in the F2052SH document that on the return journey she said: “she was glad to be back, but states she wants a single cell”. A further entry records, “States she wants a single cell, but seems very upset. Says it’s not fair that if she goes into a dorm she will be upsetting the others.”

An entry in the F2052SH at 11.25 notes: “Spoke with level 3 Senior Officer. Advised him not to put the woman in a single cell. Spoke to level 4 nurse, states that she does not have to go back to C4 for any med reasons.”

An officer recalled the woman arriving on level 3 landing after her return from outside hospital. C3 is the induction unit, normally the area that accommodates new prisoners.

The officer said that all staff were aware the woman had recently lost her baby and was subject to F2052SH monitoring. He said that the woman was initially allowed to wait in the unit’s television room while staff decided the most appropriate location.

The Principal Officer, unit manager recalled that her Senior Officer had spoken to her about the woman’s location. The PO said that she had been concerned about the woman’s physical and emotional state after the trauma of the day before. She went on to say: “So I went around with him to see her and she was, I suppose she must have been a state of shock, she just, she just seemed emotionally dead, she was numb, if I could describe it, I would say she was numb.”

The PO interviewed the woman and said that she wanted to locate her in a dormitory so that she could receive support. However, the woman said that she wanted to be located into single accommodation so that she could grieve and come to terms with her

loss. The woman refused to compromise, insisting that staff should take her to the Segregation unit if her request was not allowed.

The PO decided this would not be in the woman's interests and authorised a single cell, positioned near to the office. In doing this, the PO said this allowed staff to maintain good contact with her and to be able to monitor the woman more closely. The PO instructed that the woman be observed every 15 minutes over the lunchtime period and made an entry into her F2052SH, document recording this instruction.

The PO said that she instructed the woman's close monitoring be continued after this period. However, despite studying the F2052SH booklet, she was unable to confirm that this instruction had been followed.

The officer confirmed that the woman had been placed on a regular watch. He said: "She was put on half and I imagine that the entry's in there (F2052SH booklet), even some entries would have been every fifteen minutes 'cos it was, as I said like before, it was spelt out when [the woman] come on to C3 that she was very vulnerable and very down." This officer also confirmed that the watch frequency had been recorded on the front of the F2052SH document. However, when the inquiry team studied the booklet the actual instruction recorded was "Obs ½ hourly at night".

A doctor saw the woman that afternoon and wrote in the IMR that the woman had no suicidal thoughts, and that the woman had said she was feeling better following the change of landing. The doctor did not issue any instructions regarding the woman's level of supervision, other than those currently in place.

The doctor said that she felt that the woman had been unhappy to see her, as she had not requested to be seen by a doctor. The woman repeatedly asked if she could leave. When she left, she had been satisfied that the woman was alright.

The PO said that when the woman returned to the unit, they had a cup of tea and sat in her room for about half an hour. She said that the woman appeared to be numb.

The RC Chaplain also saw the woman that afternoon. The RC Chaplain had initially spoken to the woman during the lunch period and returned to see her at about 15.00.

At this time, she and the woman had gone to the Chaplain's office to have a cup of tea. However, the woman was too upset to drink it.

The woman and the RC Chaplain had talked about the baby, and the fact that the woman had signed a document at the hospital which gave authorisation for the baby to be cremated. They discussed attending the cremation, but the woman said that she was not sure if she could do this. The RC Chaplain reassured her, saying that she would attend in her place if she felt she could not go. Eventually, the woman stated that she wanted to go back to bed, so the RC Chaplain returned the woman to level 3.

6 May 2004

At 10:56 on 6 May, an entry in the woman's F2052SH noted that she was upset that the doctor had not written up her Methadone prescription.

The PO and the member of the Outreach Mental Health Team (OMHT) attempted to interview the woman, but she did not want to talk at that time. The member of the OMHT made an entry in the F2052SH booklet, noting that she would return later to see her, by which time she might have been given her methadone.

The woman refused to have lunch or hot water and appeared in a very low mood. At 13:30, staff found the woman hiding behind her mattress, claiming that a scan photograph of her baby had gone missing and she wanted it back.

At 15:20, the officer walked out of the office and looked into the woman's room, where he found she was sitting on the window with a green sheet, attempting to tie it to a ligature on or near the window.

The alarm was immediately raised, and with a colleague they entered the room and removed the ligature from the woman. The officer said that a female officer sat with the woman and spoke with her for sometime. A nurse attended the scene and it was decided that the woman should relocate to the Healthcare unit, C1.

The member of the OMHT, who had spoken to the woman earlier that day, had made arrangements to for the woman to be located on C1 due to her concerns. However,

before the member of the OMHT could inform the woman, she had attempted to self-harm with the ligature.

Staff in C1 told the member of the OMHT that space was available in dormitory accommodation in that unit. Upon her return to level 3 she spoke to the woman about this, and she agreed to this location. An entry made by the member of the OMHT in the woman's IMR and F2052SH document recorded this meeting and noted that she was extremely distressed at the loss of her baby, blaming herself for the death.

The woman moved to C1 before the evening meal was served. She was relocated into dormitory 8, a large room with its own toilet and wash area. Although the room was able to accommodate up to four people, at the time the woman was the sole occupant.

Prior to her admission to the unit, staff discussed where to locate the woman. It was agreed that there was no other suitable accommodation available and she should be located into the dormitory, on her own as there was no other prisoner who would have been considered suitable to co-locate with her. There does not appear to have been any consideration to using a Listener, or a friend, overnight to support her.

On arrival in the unit the woman's property was searched for items that could be harmful, and then returned to her.

The nurse in charge of the unit that evening, conducted an induction interview and welcomed the woman to the unit. She noted that the woman was the subject of F2052SH observations and also appropriately raised a Nursing Care Plan. As part of this plan, the nurse recorded that she should be observed hourly. The nurse in charge of the unit formed the impression that the woman had not wanted to be on C1.

The investigators asked why this had been the case, when on D3 Unit she had been on half hourly observations. The Nurse said that although the Care Plan recorded hourly observations, staff always looked into the cell whenever they passed. This meant that although observations were only recorded every hour, in practice these were much more frequently completed.

The nurse in charge of the unit explained that, although she had been aware of the earlier incident, she had not assessed the woman as requiring constant supervision. This assessment was based on her interview with the woman on arrival into the unit and her observations during the evening period. She briefed the incoming night staff of the woman's situation when they came on duty.

The F2052SH noted that she had an uneventful night and was observed at hourly periods throughout the night.

7 May 2004 – Discovery of the woman Suspended by Ligature

On 7 May 2004, the officer on duty, initially went to the Senior Officers office, to check the detail (Duty roster) and then to count the number of prisoners on the level.

The first officer on duty did not receive any handover or briefing from the night staff, as he was a discipline officer. Medical staff coming on duty would normally complete this task.

The first officer on duty checked on the woman and saw her to be fully dressed and sitting at the bottom end of her bed. The woman did not speak, but she looked back at him. The first officer on duty was insistent that nothing untoward was happening at that time, so continued with his remaining duties.

The nurse in charge of the unit said that she had received a briefing from the night Sister. The nurse in charge of the unit said, "Yes the night staff told me that [the woman] had a comfortable night and she was of the opinion that she doesn't like being on C1 and would like to go back to the level." She went onto say, "After when I took over from the night staff, I went to check on [the woman]. When I went she wasn't on her bed and I call, she answered from the toilet in a soft voice, that she was on the toilet."

That morning was particularly busy, with lots of prisoners required for court. One prisoner due for discharge, was proving demanding to the staff. It was decided that this prisoner would not go to the prison reception area, instead she would be taken to the court transport directly from C1.

Normally, before commencement of duty, a staff briefing takes place where the prisoners located on the unit and their continued care are discussed. However, as a result of the morning's problems, the meeting that morning did not take place immediately.

As the meeting was delayed, the dispensing Sister and Staff Nurse started to dispense the morning medication. They collected the medication trolley and walked past the woman's dormitory to the far end of the level.

They began working back towards the woman's dormitory, dispensing medication as they went. On arrival at dormitory 8, they prepared the woman's medication. They both looked through the door's observation hatch and saw her suspended by a ligature secured to the window.

The dispensing Sister called for assistance. Staff responded quickly and entered the room, either at the same time or very shortly after the dispensing Sister. The first Officer into the room ran over to the woman and supported her weight, whilst the dispensing Sister, using her scissors, cut the ligature. The woman was then placed on the floor.

The Lead Nurse responded and entered the room. He assisted in moving the woman to the floor. He checked to see if she was breathing, and felt for a pulse. He began mouth to mouth, initially using a one-way valve and then by ambubag and oxygen when it arrived. On the initial discovery of the woman, the dispensing Staff Nurse went to the unit's treatment room and collected the Emergency Medical Equipment trolley.

The first officer on duty responded too. He said: "they had cut her down and was just laying her down. And I went around the side of the woman, checked for a pulse whilst [my colleague] was checking for breathing, she was very cyanosed, blue in the face, and there was no breathing, I couldn't feel a pulse, so myself and [my colleague] started. [My colleague] breathing, or attempting to breathe and myself on chest compressions."

The Lead Nurse said that initially he had difficulty in obtaining a clear airway and thought that there might be a blockage. However, aided by the first officer on duty he was able to tilt the woman's head back, which allowed air to enter her body. He continued, with the first officer on duty, delivering Cardio Pulmonary Resuscitation (CPR), later moving position to the woman's chest and taking over chest compressions.

The Senior Officer (SO) was working in her office on C1 level, when she heard the shout for assistance. On leaving her office, she saw the Lead Nurse, the first officer on

duty, the first officer in the room and two Nurses entering the woman's dormitory. The SO attended and observed the woman suspended by a ligature.

The SO used her radio and called for an ambulance. However, the Communications room said they needed more information and to contact them by telephone. The SO said there appeared confusion on the radio net at the time and the General Alarm had not been sounded over the net.

The SO went to the office to telephone the Communications room, but the Head of Healthcare, was already on the telephone, to the Communications room. Additionally the Head of Healthcare requested the presence of a doctor and Hotel 5 (the code for the duty Senior Nurse responsible for emergency response).

Hotel 5, the duty Senior Nurse, was called to attend and the SO commenced an Incident Scene Log.

On arrival, the duty Senior Nurse saw the staff actively conducting CPR and offered to relieve them. They all declined her offer, so she started to prepare an IV and other medical equipment for use. However, this was not used as the London Ambulance Service crew arrived at the scene soon afterwards.

The Orderly Officer³, Principal Officer said that she was working in her office when she heard a radio transmission requesting Hotel 5 to attend the hospital (C1). Realising that this was an unusual request, she immediately made her way to the area where the SO briefed her.

The Orderly Officer said that when she arrived at the scene, she saw the Lead Nurse carrying out mouth-to-mouth and the dispensing Sister completing chest compressions. The Orderly Officer said that although the dispensing Sister had initially managed the scene, she was in a distressed state and decided to relieve her. The Lead Nurse then took over chest compressions and she replaced him carrying out mouth-to-mouth.

³ Principal Officer responsible for ensuring the prison regime is running correctly, and responsible for the management of Incidents.

Staff actively engaged in the delivery of CPR continued in their attempts to revive the woman and rotated on all key elements.

Request for Ambulance and Management Response

The Operational Support Grade⁴ was working as the Communications Officer on that morning. When the Head of Healthcare called to request an ambulance, she immediately contacted the London Ambulance Service using the 999-emergency number.

The Communications Officer told the Emergency Operator that a prisoner had been found suspended by a ligature, in her cell and was not breathing. The Operator said that he had dispatched an ambulance under a “blue light” tasking.

The Communications Officer told the prison gate, advising them that an ambulance was en-route. She told staff to cover the route from the main gate to C1 level entrance, so on arrival the ambulance would have a clear passageway.

The Duty Governor was in the Communications room at 08:14, when the radio message reporting the incident was received. The information passed from the Officer requesting an ambulance was sparse and additional information was requested.

The Duty Governor explained that, while the radio operator calmed the person down, he left the room to tell other managers of the incident. The Governor was in the Deputy Governor’s office and he explained that he was going to attend the scene of an incident. The Governor went to the Communications room.

The Duty Governor made his way to C1 level, instructing a Principal Officer to accompany him. When they arrived at the scene, the woman had been placed on her back and staff were actively administering CPR.

The Duty Governor took charge of the area, ensuring the entrance was clear and ready for the arrival of the ambulance, and began to take notes of the times of various events that then took place. A defibrillator was requested, and the Duty Governor relayed this request to the Communications room, who in turn contacted two further nurses by radio to facilitate this request.

⁴ OSG (Prison Officer Auxiliary)

The nurses were not made aware that this request was urgent. The fact that no alarm bell had been sounded contributed to their belief that this was not an urgent situation. They collected the defibrillator and walked to C1.

At 08:22, staff from a London Ambulance Service Rapid Response Vehicle (RRV), arrived at the scene. Soon after this, a supporting ambulance arrived. They attached their own defibrillator to the woman, and the prison one was not required.

The woman was placed into the ambulance, where a member of the ambulance crew took over CPR. She was taken to the Accident & Emergency Department at the hospital, where she received further treatment and was admitted to the hospital.

Post Incident Action Taken and Admission to Hospital

Establishment Contingency plans were put into effect and a staff hot de-brief was conducted. Staff Care and Welfare Service were made available to anybody who felt they needed help or assistance.

The Duty Governor was identified as the establishment's Family Liaison Officer. He attended the hospital, where he met the two escorting prison staff. The woman was in the hospital's crash room. At 12.10 the Nurse in Charge of the crash room area said that the woman now had a heartbeat. She was intubated to assist her breathing.

The Duty Governor was told that the woman's family was due to arrive at the hospital, so he waited for them. On their arrival he met with the woman's mother, brother and sister. The Duty Governor said that the woman's brother requested that the escorting staff be withdrawn. The Duty Governor agreed to discuss this with the establishment.

Unfortunately, despite all treatment given the woman failed to respond. She died the following day at 13:45hrs, 8 May 2004.

Findings

The woman was identified as being vulnerable to self-harm and/or suicide. Staff, both with the Court Escort Service and at Holloway, took the appropriate action in raising documentation, opening an F2052SH booklet and placing her on this monitoring system.

During the initial period of the woman's custody there were a number of incidents of self-harm and minor disciplinary problems. However by 20 April 2004, she appeared to have settled and was looking towards the future.

On reception, the woman disclosed her pregnancy to staff and explained the circumstances surrounding this. She was given support and offered long term help to cope with this situation. Initially, the woman wanted to terminate her pregnancy. However, she decided to keep her baby and was working towards a new start, with her baby as the pivotal point of her future.

She requested a reduction in her methadone treatment, to minimise the possible harmful effect on her baby. Medical opinion says that this would not have caused any adverse effect to her pregnancy. However, the reports that the woman had been suspected of involvement with illicit drugs are of concern. I note though that these are suspicions not facts.

It is regrettable that the woman's progress, in respect of self-harm, was set back by the inappropriate remarks of an Officer on 28 April. This resulted in the woman self-harming and her return to the F2052SH monitoring system. The establishment dealt with this incident properly and, it appears, to the satisfaction of the woman herself.

On 3 May 2004, the woman experienced pain in her stomach and was taken to the Hospital, where she was later to receive confirmation that her baby had died. It goes without saying that the loss of a baby is hugely traumatic for any woman. For someone as vulnerable as the woman, the impact must have been almost unbearable.

Prison Staff showed sympathy and understanding of the woman's situation. They offered help and support to the woman in her attempts to overcome this tragedy.

The woman decided, against medical advice, to return to the prison on 5 May 2004. Staff in the prison was made aware of the circumstance of her loss and that she was on an F2052SH. On her return, she was returned to the prisoner induction level, C3 and not to the pregnant women's level, C4. This decision was understandable and made with the woman's agreement.

The Manager of C4 level said that in circumstances where prisoners have lost babies it would be normal practice for the C4 level Senior Officer to complete a Care Plan for the woman to help them deal with their loss. Unfortunately as the woman had not returned to the pregnancy unit, such a Care Plan was not completed. Indeed, there appears to have been no thought given to providing a plan and contact with level 4 staff either did not take place or was very minimal.

The woman's return to C3 concerned the level staff. The admission to the level was brought to the attention of the level Manager who, after speaking with her for a considerable time, directed that she be allocated to a cell where she could be closely monitored. This Manager set an appropriate level of staff supervision and ensured that all staff received a briefing on the situation.

Over the course of the remaining part of that day, and the following day, the woman was seen by a number of the multi-disciplinary team offering her re-assurance and support in her situation.

Having acknowledged the input made by these individuals, it is surprising that there appears to have been no attempt to co-ordinate these efforts. A case review should have been conducted, which should have included input from the woman.

The woman was managed on C3 level, initially on fifteen-minute observations and then later on thirty-minute observations. Given the circumstances of her history and her return to the prison, this was an appropriate level of supervision. However while the 15-minute watch instruction was recorded in the F2052SH, the thirty-minute watch instruction was not.

Following the concerns of the Outreach Mental Health worker on 6 May 04, the woman was relocated to dormitory accommodation in the hospital. However, prior to this

transfer, staff discovered the woman with a ligature around her neck. Staff and the nurse from level 3 spoke with her, but there is no evidence that a case review to address her needs or to assess the level of supervision that she required was ever considered.

According to the member of the Outreach Mental Health Team, both she and the woman expected the dormitory to be shared accommodation. However, the woman was located into a dormitory on her own. Staff state there was no other suitable accommodation available and no other patients in the hospital suitable to share with the woman.

A prisoner who co-ordinated the Listeners Scheme within the prison, said that she had listened to the woman in the past and was aware of the woman's loss. The prisoner was available on the night of 6/7 May and was aware of the woman's return to the prison. She said that, had she been asked, she would have been happy to stay with her that night. It would appear that this was not considered.

The woman was interviewed when she arrived in the hospital unit, in line with normal procedures. The Nurse in charge of the unit completed the reception document, however the 'Risk Assessment' section was not completed. A Care Plan was raised and it was agreed that "hourly observations" should to be carried out.

In line with the plan, the woman's level of supervision decreased from every thirty minutes to hourly. However, in practice Hospital staff claim that this was not the case. They say that all staff regularly looked into all of the hospital rooms as they passed by. In the opinion of staff, the level of supervision would actually have increased, although this is an informal arrangement. As a consequence, this was not reflected in the woman's F2052SH. Staff said that, this document was not relied upon in healthcare, as all entries were made in the prisoner's Care Plan. The Care Plan does not reflect this claim.

I have reviewed both the F2052SH and the Care Plan. One period was identified where for four hours no entry had been made in either document. The assertions made by staff that the level of observation had increased are not evidenced by the documentation

There were no recorded untoward incidents during the night of 6/7 May and staff observed the woman sitting on her bed the following morning. The Nurse, who admitted the woman to the ward the previous night, spoke briefly with her after receiving a hand over from night staff.

When, around 30 minutes later, the woman was found with a ligature around her neck all staff responded to the emergency without delay. Everyone involved worked extremely hard to revive the woman and were deeply affected by the incident.

It is regrettable that staff were unable to carry out certain emergency medical procedures due to a lack of formal training and experience. It is also a concern that although a coded system exists within the establishment advising staff about the seriousness of a medical emergency, it is only used at night. Had this have been in use, it would have alerted key personnel to attend.

The deployment of the defibrillator was not regarded as urgent.

It is clear from the attached report from the Suicide and Self Injury Prevention Consultant that a number of incidents, when the woman self-harmed were not properly recorded. I am concerned that this may be indicative of a wider problem of under recording.

Conclusions

The level of non-compliance with Prison Service Policy and Orders identified in the specialist reviews is unacceptable and should be addressed immediately.

HMP Holloway failed to provide a co-ordinated approach to the support of the woman on her return from hospital to the establishment, after she had lost her baby.

The level of supervision set for the woman within the Healthcare unit was insufficient. It did not take account of her previous self-harm history and of the circumstances of her re-location to that unit. It is not always possible to prevent someone from self-harming. However, in this case, if she had been in shared accommodation or on a Constant Watch it would have reduced the likelihood of harming herself or taking her own life. In addition, it would have provided an early warning, of the way she was feeling.

Following the discovery of the woman's attempt on her life on the morning of 7 May, staff responded quickly and worked tirelessly in their effort to sustain her life. This medical intervention was partially successful, as the woman's condition did not deteriorate. However, despite the request for a defibrillator not being relayed as urgent, healthcare professionals ought to have realised that life-saving equipment was being requested, and treated the request as an urgent one.

Recommendations

I make the following recommendations: -

National

1. Safer cells should be installed at strategic locations within Holloway.

Local

1. I recommend that a system be considered for listening to the telephone calls of all prisoners subject to F2052SH monitoring.
2. I recommend that the first member of staff on duty in the Healthcare centre should receive a written briefing. This can then be shared with staff as they arrive.
3. I recommend that the Governor remind his staff of the information required by the Communications room in an emergency.
4. Prisoners subject to F2052SH monitoring arrangements should be monitored on a regular, but not predictable basis. The level and frequency of observations should be clearly documented in the F2052SH and compliance monitored by management.
5. Entries in the F2052SH should clearly demonstrate appropriate interaction with the prisoner to enable effective assessment of their mood and demeanour.
6. Entries in the woman's F2052SH state that she was located in a 'safer' cell. However, Holloway has no safer cells. It is an issue for concern that staff may perceive a non-safe cell to be 'safer' in that it may provide a false sense of security. The Governor should remind his staff about what a safer cell is.
7. The Governor should ensure that when a prisoner displays suicidal behaviours, intent, self-injury or suicide attempts, a multi-disciplinary case review takes place to review the prisoner's care and support plan. A review should also take place following any significant event in the prisoner's life.

8. The Governor should ensure that all F2052SH case reviews are multi-disciplinary and have support plans that are relevant and specific to the prisoner's care. The Governor should ensure that these are effective.
9. The Governor should ensure that Management checks assess the quality of the F2052SH itself and whether or not it complies with Prison Service and local policies.
10. Prisoners subject to increased observation as a result of being at risk of deliberate self-injury should be located in shared accommodation wherever possible. There must be clear documented evidence of a multi-disciplinary review, and the reason for location in single accommodation if shared accommodation is not an option.
11. Consideration should be given to the use of Listeners over-night on a short-term basis if there are no prisoners suitable to share accommodation.
12. The Governor should ensure that all incidents of self-injury/attempted suicide or noose/ligature are recorded on the Prison Service's Incident Reporting System.
13. Prisoners received in Holloway who state they are receiving treatment from their own GP or other specialist should have their prescription (type and dose) and other continuing care arrangements confirmed with the practitioner.
14. Prisoners received in Holloway who identify on reception that they have a psychiatric history should be immediately referred for a comprehensive psychiatric assessment by an appropriately qualified health care professional.
15. There needs to be a documented multidisciplinary plan of care, with good communication and team working between the various agencies, for all vulnerable women.
16. A 'Care Programme Approach' as outlined in the report on the confidential enquiry into suicides and recommended in the report on confidential enquiry into maternal death should be implemented.

17. Observations, including Temperature Pulse Respirations, Blood Pressure and withdrawal monitoring, should be undertaken for all women upon admission to the detoxification unit for a minimum of the first 72 hours in accordance with PSO 3550.
18. Clinical drug screen urine testing must be undertaken on day three for all pregnant drug users, and a negative result achieved before transfer to a residential location.
19. Clinical drug screen urine testing must be undertaken twice weekly for all pregnant drug users throughout their pregnancy, in accordance with agreed women's prisons protocols. The results of these tests must be entered in both the nursing care plan, and the hand held antenatal records.
20. When security information regarding possible illicit drug use/dealing is known, and the prisoner is in receipt of a methadone maintenance prescription, this information must be shared with healthcare staff who, in accordance with agreed protocols must test the patient's urine and observe for other signs of intoxication before any methadone is given.
21. The standards of record keeping need to be urgently reviewed and appropriate training delivered to ensure all staff meet as a minimum the standards laid down by their professional bodies.
22. Joint assessment and care planning between the mental health team and the substance misuse team needs to be evidenced.
23. A review of practice with regard to fitting for cellular confinement should be undertaken with advice from the Suicide and Self Injury Prevention Consultant.
24. I recommend that the Governor of Holloway commissions an investigation into the circumstances that led to the delay in bringing the defibrillator to the scene of the incident.

Part 2 – Specialist Reviews

1. **Management of the woman's F2052SH** by the Suicide and Self Injury Prevention Consultant (PhD Forensic Psychology) , Women's Team, HM Prison Service.
2. **Review of Clinical Management of the woman's Substance Misuse** by the Nurse Consultant on Substance Misuse, Women's Team, HM Prison service.
3. **Clinical Review of the woman's care during period of custody** by the Lead Consultant Psychiatrist in Substance Misuse (BMedSci, BM, BS, MRCPsych, DM, Section 12 Approved), , Camden & Islington Mental Health & Social Care Trust.
4. **Midwifery Officer's Clinical Review** by the LSA Midwifery Officer.

The Suicide/Self Injury Prevention Consultant – Management of the woman’s F2052SH

This section is a report by the Suicide and Self Injury Prevention Consultant, Women’s Team, HMPS, which was commissioned to identify HMP Holloway’s compliance with current Prison Service Orders in regards to the woman’s treatment whilst she was subject to the F2052SH monitoring system.

The Suicide and Self Injury Prevention Consultant refers within this report to a second report commissioned by the London Area Manager, in response to concerns raised by the inquiry team. The Area Manager authorises the disclosure of this report to the investigation team and it is attached at annex V1-64.

Introduction

This report, on the management of the woman’s F2052SH between 1 March and 8 May 2004 at HMP Holloway, has been prepared at the request of the Prison Service Senior Investigating Officer, to assist with the investigation into her death in custody. It should be read in conjunction with the (forthcoming) investigation into HMP Holloway’s Suicide Prevention Procedures, as commissioned by the Area Manager for London.

In preparing this report I have met with the Senior Investigating Officer on several occasions. A verbal summary of the time the woman spent in custody (from her remand to HMP Holloway on 1 March to her death at the Hospital on 8 May) was provided, along with a chronology of events. I have received copies of the two F2052SH documents that were raised during her time in custody (1 March – 20 April and 28 April to 7 May 2004), which form the basis of this report. In addition, I have had sight of HMP Holloway’s Suicide Prevention Procedural Document and refer to it where relevant.

Because of the volume of documentation available, only salient elements will be discussed within this report. Throughout the report examples of where local or national suicide prevention procedures have not been fully applied are shown in *italicised* typeface.

Reported Incidents of Self-Injury/Attempted Suicide

Detailed below are the recorded incidents of self-injury/attempted suicide and/or suicidal ideation relating to the woman between 1 March and 7 May. The second and third columns show the date and method of self-injury respectively; the fourth column shows where the incident was reported; only four of these incidents were reported via the Prison Service Incident Reporting System⁵.

No	Date	Type of Injury	Source
1	02/03/04	Cut left arm	IMR/F2052SH
2	02/03/04	Found suspended by a sheet from her window	F2052SH
3	04/03/04	Reporting wanting to kill herself	F2052SH
4	04/03/04	Tied ligature to cell window bars and stated she wanted to kill herself, ligature removed by staff	F2052SH
5	07/03/04	Superficial cuts to both arms	IMR
6	18/03/04	Reported wanting to kill herself	F2052SH
7	18/03/04	Seen by CMHT and expressed active suicidal ideation	F2052SH
8	22/03/04	Cut left arm	F2052SH
9	22/03/04	Cut right arm	F2052SH
10	02/04/04	Barricaded in room and seen making a ligature	History Sheet
11	03/04/04	The woman reported to staff that she would "smash up" and harm herself	Obs Book
12	03/04/04	The woman reported to staff that, when she sees glass she feels like harming herself	F2052SH
13	28/04/04	Several lacerations to arms with an ashtray	F2052SH
14	28/04/04	The woman requested that the flap to her door be left open. When request declined she became abusive and told staff she would injure herself.	History Sheet
15	29/04/04	Inflicted superficial cuts to her left arm	IMR
16	04/05/04	Said would smash her lamp and cut herself	F2052SH
17	06/05/04	Seen sitting on her window with sheeting around her neck	F2052SH
18	07/05/04	Found suspended from a ligature. Resuscitation unsuccessful	F2052SH

F2052SH Case Reviews

For all but eight days of her time at HMP Holloway the woman was on an open F2052SH. According to national Prison Service instructions (PSO2700) an initial review of a prisoner on an open F2052SH must take place within 72 hours.

Subsequent reviews should take place as often as necessary, but at no longer than fourteen-day intervals. Reviews should also take place following incidents of self-injury/attempted suicide (unless otherwise stipulated within the prisoner's care plan).

⁵ As set out in Prison Service Order 52/2002, all incidents of 'self-harm' (defined as any act where a prisoner deliberately harms themselves irrespective of method, intent or severity of injury. Noose/ligature making should also be reported) must

As stated in PSO 2700, reviews should be multi-disciplinary (i.e., including relevant staff of more than one discipline as well as the prisoner concerned).

Shown below is information relating to the reviews of the woman's F2052SH. The first and second columns show the date of and reason for the review respectively. The third and fourth columns show the range of staff present at the review and whether or not the woman was present (according to the summary of the review contained in her F2052SH). The final column shows the level of required observation as set by the review panel.

Date	Reason	Range of staff	The woman present	Observation
04/03/04	72 hour review	Senior Officer (SO)	Yes	2 x hourly night 8 x hourly day
12/03/04	Presumed routine but date not specified	SO, member of Mental Health Team	Yes	½ hourly
16/03/04 undated	Routine; date set at previous review	Senior Officer, Nurse	No	½ hourly night 8 times day
23/03/04	Routine; date set at previous review	SO x2, Probation, Psychology	No	½ hourly night 8 times day
31/03/04	Routine; date set at previous review 30 March	SO. Ms Waite didn't want anybody else present	Yes	½ hourly night 8 times day
06/04/04	Routine; date set at previous review 07/04	SO, Officer	Yes	½ hourly night 8 times day
13/04/04	Routine; date set at previous review	SO, Officer, Probation	No	½ hourly night 8 times day
20/04/04	Routine date set at previous review	SO x 2, Officer, Probation, Chaplain	No	F2052SH CLOSED
01/05/04	72-hour review for second F2052SH opened 28/04	SO, Officer	Yes	No observation level set

As indicated, four of the nine case reviews included only discipline staff and were not, therefore, multi-disciplinary; it should be noted that, in one of these cases, it is documented that the woman had stated that she did not want any other staff members present.

As indicated, all of these case reviews were either routine (i.e., following on from a previous review) or were conducted (in accordance with Prison Service procedures) within 72 hours of the F2052SH being initiated. *There is no evidence of a case review being conducted following the incidents of attempted suicide/self-injury outlined above. This is contrary to current instructions (i.e., PSO 2700).*

be recorded on the form F213SH; this information must then be forwarded for entry

Findings

1. The first F2052SH in respect of the woman was raised when she was first received into custody at HMP Holloway (at 1615 hours on 1 March 2004). The initiating member of staff noted (on Page 1 of the document) that the woman was upset; she was withdrawing from drugs and had a history of previous self-injurious behaviour. The member of staff recommended that the woman be observed, that she may benefit from a befriender and that she should be offered rape counselling.

2. The woman saw a nurse at 1720 hours on 1 March for an assessment under F2052SH procedures. Based on her assessment the nurse recommended that the woman was located in a dormitory on H1 and that she be observed at “routine” intervals.

The nurse’s recommendation regarding the required level of observation for the woman should have been more specific than “routine”. Holloway’s Suicide Prevention Procedural Document states that, unless a prisoner is on ‘intermittent’ or ‘constant’ supervision, a minimum of three entries must be made both during the day and during the night. Presumably, the Nurse, in stating that the woman should be observed at “routine” intervals was referring to the minimum prescribed level of observation (i.e., 6 observations in a twenty-four hour period). Nevertheless, the nurse should have stated this in the woman’s F2052SH. Further, it is unclear whether or not the nurse’s recommendation that the woman should have been placed in a dormitory was acted upon or if she were placed in a single room.

3. In accordance with F2052SH procedures, a doctor assessed the woman within twenty-four hours of her assessment by the nurse (at 1745 hours on 1 March). The doctor made the following comments on Page 5 of the F2052SH:

“Says will kill herself but did not express suicidal ideas. Wants more medication. Very angry”.

The doctor has stated that the woman did not express any suicidal ideas; that she has said she intends to kill herself appears to be contradictory to his overall assessment

(i.e., that she has no suicidal ideas). The doctor recommended that the woman was located on the detoxification unit and gave no further instructions.

Contrary to current instructions the doctor did not complete Page 6 of the F2052SH.

4. Having undergone routine reception procedures the woman was located on unit H1 (Holloway's detoxification unit). The Unit Manager completed Page 2 of her F2052SH at 1150 on 2 March and, in addition to reiterating the recommendations made by the initiating officer as outlined above, suggested that she be given access to probation and that she should try to maintain contact with her family. It was also noted that the woman was angry at being in prison and that she had said she was pregnant as a result of a rape.

HMP Holloway's local Suicide Prevention Procedural Document states that the relevant Residential or Unit Manager should complete their assessment immediately and advises that they should involve other staff in the decision-making process. In this case the Residential Manager completed their assessment after a period of nineteen hours. There is no evidence that other staff were involved in the decision-making process.

5. As mentioned above, the nurse who conducted the woman's initial healthcare assessment recommended that she be observed at "routine" intervals. The first entry in the Daily Supervision and Support Record was made at 1930 hours on 1 March and the second an hour later. Throughout the night she was observed at half hourly intervals and, during the following day, mainly at hourly intervals. Throughout this time staff have made a number of entries that relate to the woman's (self-described) suicidal ideation, for example:

"Spoke briefly with [the woman]. She said he wasn't feeling well enough to talk to me – but she did say she felt suicidal/like self-harm [because] of all of her problems and she would like one-to-one" [1020 hours on 2 March 2004].

"[The woman] says she is feeling very suicidal at the moment. Staff to keep an eye on [her] for now" [1435 hours on 2 March 2004].

Following the entry at 1435 hours, the woman's F2052SH contains no evidence of further observations until 1650 hours – i.e., more than three hours later. Given the woman's apparent suicidal ideation it may have been prudent to instigate a case review in order to review her level of observation and support plan. There is no evidence that any such review took place.

6. At 1930 hours on 2 March, the woman was found to have inflicted superficial cuts to her wrist and was subsequently treated by a nurse.

Contrary to current instructions, no case review took place following this incident.

7. An entry at 2030 hours on 2 March notes that the woman was relocated into Room 30 (a 'safe cell') and that she appeared "now fine". However, later that evening (at 2150 hours) the woman was found to be "suspended by a bed sheet from the window, thereby suggesting that the cell had obvious ligature points and was not, therefore, safer. Given that Holloway do not actually have any 'safer' cells, it is a matter for concern that a member of staff placed a vulnerable prisoner in a cell that they (mistakenly) believed to be safer than the cell in which they were previously located.

Contrary to current instructions, this incident was not followed by a review of her F2052SH's support plan or level of observations.

8. At 0950 hours on 3 March 2004, Holloway's Suicide Prevention Co-ordinator made the following entry:

"SPC check. Apparently last night's acts of self-harm were regarding a phone call. Arrangements made with level S/O [Senior Officer] to allow phone call to mother" (0950 on 3 March 2004).

Irrespective of the woman's motivation for the previous evening's events, it remains that a multi-disciplinary case review should have been held. It is a matter for concern that the Suicide Prevention Co-ordinator did not bring this omission to the attention of the Unit Managers or the Orderly Officer.

9. Subsequent entries during the following twenty-four hours indicate that, although the woman was tearful, upset and angry on occasion, she did appear to settle somewhat after being able to speak to her mother on the telephone (on 3 March). During this period, there is evidence that the woman was offered the opportunity to participate in some activities (e.g., resettlement, contact with Chaplaincy, 'Revolving Doors' and association) and, indeed, did do so. An entry at 1245 hours on 4 March notes that staff "had to enter [her] room to take materials away from her to stop her from hanging herself". *No mention is made of precisely what materials were taken away.* Observations continued to be conducted at (mainly) hourly intervals during the day and half-hourly intervals at night. *A management check (conducted at 0950 hours on 4 March) notes the need for a 72-hour review that day; this review was completed on 5 March (i.e., 24 hours late).*

An entry at 2005 hours on 4 March is as follows:

"Asked if she could have her nighty. I asked if she would behave herself and she said she couldn't make any promises. So nighty not issued".

As mentioned above, the entry made in the woman's F2052SH earlier that day refers to the removal of "materials". It is assumed that this action was taken in an attempt to minimise the woman's opportunities to injure herself. Current instructions state that information about the removal of items in a prisoner's possession, as well as the reasons for the removal of such items, must be documented in the person's F2052SH. No such entry was made. Further, the entry at 2005 hours suggests that the woman's nightclothes were among the items removed. This entry raises questions concerning the woman's access to night clothing. Further, the tone of the comment "I asked her if she would behave herself" could be perceived as being somewhat pejorative.

10. The woman's F2052SH was first reviewed at 1930 hours on 5 March (i.e., more than 4 days after it was first raised). *Current instructions state that the initial review of a prisoner identified as being at increased risk must take place within 72 hours. Further, only one member of staff (a Senior Officer) was present at the case review and there is no evidence of the woman's presence.* The member of staff who conducted the review has clearly detailed the woman's concerns, which related to the fact that she was pregnant, was undergoing detoxification and was concerned about

the lack of contact from her family. A support plan, based on these issues, was initiated. *However, the level of observation specified is open to interpretation, as follows: 2 x hourly night obs/ and 8 x hourly obs during the day. The intention may have been that the woman should have been observed twice an hour at night and eight times an hour during the day or, alternatively, once every two hours during the night and once every eight hours during the day (a more likely scenario).*

11. Entries in the woman's F2052SH subsequent to this review continued to be made at, more or less, half hourly intervals at night and hourly intervals during the day. An entry at 1915 hours on 6 March states that that "[the woman] wants to speak to a SO [Senior Officer] or a befriender". *An entry at 1300 hours on 7 March states that the woman was then "talking to a Listener" (i.e., eighteen hours after her initial request to see a 'befriender').* A subsequent entry at 1830 hours on 9 March notes that the woman is "not happy. Waiting for a Listener", although there is no evidence that she was seen. According to her Daily Supervision and Support Record, the woman changed location (to D0) at 1945 hours on 8 March. *There is no note of the type of accommodation in which the woman was located (bearing in mind she was in a 'safe' cell) or if she was placed in shared accommodation.*

12. The woman appears to have been transferred to court on 9 March. An entry at 0645 hours notes that she was received into reception. A later entry (at 2100 hours) notes that she was "fine, sorting out her bed".

13. The woman's F2052SH was reviewed at 1600 hours on 12 March, with a Senior Officer, a member of the Mental Health Team and the woman in attendance. The review summarises the woman's then concerns (i.e., lack of visits/contact with her family and indecision with regards to her pregnancy). The support plan reflects these concerns and recommends half-hourly observations. *Subsequent entries in the woman's F2052SH provide no evidence that half-hourly observations were adhered to (either later that day, during the following evening or subsequent to that date).*

14. The next case review was held on 16 March (although the form is unsigned and undated). A Senior Officer and a Nurse were in attendance. The summary of the review is basically a reiteration of previous reviews: i.e., the woman has stated that she is suicidal, is distressed about her pregnancy and is missing her family. She

expressed a wish to have contact with the psychology department. The support plan arising from this review is appropriate, based on the woman's needs: i.e., referral to psychology, Community Mental Health Team, to continue with CARATS support group, to encourage engagement in purposeful activities, access to Listeners/Samaritans. The level of observation was set at eight hourly during the day and half hourly at night. *These observations were not adhered to during the night of 16/17 March*

15. An entry in the woman's Daily Supervision and Support Record (at 1100 hours on 18 March) notes that a member of the Mental Health Team saw her. She is described as being actively suicidal and there is a recommendation that she is "watched closely". Following this entry, there is evidence that the woman was observed with greater frequency and staff's entries are of a more detailed nature. An entry later that day by a Principal Officer instructs staff to conduct a case review the following day – in the light of the earlier entries and apparent escalation in the woman's suicidal ideation - and to increase her level of observation to every 20 minutes. *There is no evidence that this case review was conducted until 23 March – i.e., five days after this instruction. Further, the instruction that the woman was observed every 20 minutes was not adhered to.*

16. An entry at 1140 hours on 22 March notes that the woman had cut her left arm and had been attended to by a nurse. *As with other incidents as described above, this incident was not followed by a multi-disciplinary case review. Neither is there any evidence that the higher level of observation a Principal Officer had instructed staff to adhere to (on 18 March) was complied with, either before or after this incident. The woman cut her right arm at 1850 hours on 22 March. No case review was conducted.*

17. A further case review, which was held on 23 March, was attended by two Senior Officers and a member of each the Probation and Psychology Departments. There was no representation from healthcare staff. The summary reiterates the issues outlined within previous case reviews. The support plan was similar to others described above: that she should be observed at least eight times during the day and at half hourly intervals at night; that she should have access to Listeners and Samaritans; that she should maintain contact with CARATS; and that she should have one-to-one counselling with the psychology department.

18. *The level of observation documented in the woman's F2052SH on 23 March (i.e., at half hourly intervals during the night) was not adhered during the nights of 24-25 March, 25-26 March or 26-27 March, 28-29 March or 29-30 March. This is despite entries made by a Principal Officer reminding staff of the need to adhere to the levels of observation set at the woman's F2052SH review (see entries at 1415 hours on 25 March and 1200 hours on 26 March). No entries are made in the woman F2052SH at all during the night of 30-31 March, following a change of location.*

19. An entry at 0830 hours on 26 March notes that the woman was "agitated because she wants to contact her mother". Apparently the woman had asked to make the telephone call from the wing office (as she had done on a number of previous occasions) and was told that she could call her mother using the PIN phone system. Her F2052SH states that she "cut up because she could not make the call despite being told to wait for [a Senior Officer] to come back from exercise".

20. An entry at 0845 hours on 2 April reads as follows:

"Lost her temper this morning and threw her TV out of her room. Is barricading with furniture and making a ligature with the bed sheets. Assistance called."

A subsequent entry at 0915 hours notes that the woman had been seen by a nurse and was being relocated to the Segregation Unit, pending an adjudication for damaging prison property.

In accordance with Prison Service procedures (i.e., PSO 1700) a Segregation Safety Algorithm was conducted (at 1153 hours on 2 April). The member of staff who completed the documentation recorded that, in their opinion, there was no indication that the woman would be unable to cope with a period of segregation, that her mental state would not deteriorate as a result of being located within the Segregation Unit and that that she was not actively unwell.

With regards to the location of an at-risk prisoner within a Segregation Unit, PSO 2700 gives the following instruction:

Special consideration should be given to prisoners on an open F2052SH who are segregated either under Rule 45 (YOI Rule 49) or who are subject to an adjudication or have been located in the segregation unit as a result of their adjudication hearing. The risk of locating the prisoner in a single cell in these circumstances should be considered. Adjudicators should consider the implications of the punishment they may impose on a prisoner who is found guilty at an adjudication, and who is subject to F2052SH procedures, such as removal from association, loss of canteen and cellular confinement (see the Prison Discipline/Adjudication's Manual) – PSO 2700 (Paragraph 4.2.2.3).

With regards to the requirement that 'special consideration' is given to prisoners who are on an F2052SH and placed within a Segregation Unit, the attending governor has noted (in the Segregation Safety documentation at 1100 hours) that the woman should be observed at a minimum of three times per hour and that her F2052SH should be reviewed during the afternoon of 2 April. *Her F2052SH was not reviewed during the afternoon of 2 April (it was next reviewed on 6 April), neither is there evidence (within the woman's F2052SH) that she was observed three times an hour subsequent to this recommendation was given - in fact the woman was observed with less frequency (during the night of 2/3 April) than was recommended in the previous case review.*

Further, PSO 2700 gives the following (mandatory) instruction: "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". *There is no evidence that a mental health assessment was undertaken during the 29 hours the woman spent in the Segregation Unit.*

21. The woman was relocated from Holloway's Segregation Unit and returned to C4 on 1600 hours on 3 April 2004. The first entry made during her stay on C4 states that The woman said she may ask staff to remove her television from her room if she is tempted to cut herself with the glass. Indeed, an entry at 1030 hours on 5 April states that the woman's television was removed and later returned.

22. F2052SH entries during the woman's initial stay on C4 suggest that she appeared more settled. Overall, there is less evidence that she was upset or tearful and there were few recorded incidents of self-injury (compared with her earlier stay in

Holloway). However, several entries suggest that the woman was disturbed by the noise made by women housed on C1. The review of the woman's F2052SH (on 6 April) reiterates that she was feeling more settled. The support plan includes access to off-wing activities, access to Samaritans and Listeners, the provision of a radio and observations at half-hourly intervals during the night and a minimum of eight observations during the day. As with previous F2052SH reviews, this review was not multi-disciplinary (having been attended by a Senior Officer and an Officer).

23. The woman appeared in court on 7 April and was, once again, returned to custody in HMP Holloway and located in C4. Nothing of particular note was entered in the woman's F2052SH between 7 April and 13 April (when it was next reviewed) apart from one management check that, again, instructed night staff to adhere to the stated level of observation (see entry at 1410 hours on 12 April). The woman F2052SH was reviewed by a Senior Officer, and Officer and a Probation Officer on 13 April. Again, note is made of her progress and the fact that she had not harmed herself since her arrival on C4. The support plan suggested the same level of observation as that previously, that the woman should be encouraged to take place in activities, that she should have access to Listeners and Samaritans and that she should remain in a single cell.

24. The woman F2052SH was reviewed (and closed) on 20 April. The summary of the review notes that, although she was settled on C4, she was worried about her forthcoming court appearance and said that other women had been talking about her. The woman was due to begin counselling sessions with the psychology team and it is noted that she received support from the chaplain. On balance, given that the woman had not injured herself for some time, and had shown signs of improvement, it seems reasonable for her F2052SH to have been closed. However, it would have been good practice to follow-up on her progress.

25. An F0252SH was opened at 1915 hours on 28 April 2004 after the woman inflicted several lacerations to her left arm having used an ashtray. Page 2 of her F2052SH (completed by the unit manager) notes that she had become upset about a remark a prison officer had made about her (and about which she'd apparently made a complaint). The unit manager suggested that the woman should be seen by a nurse and doctor; that she should "stay away" from the officer against whom she had made a

complaint; that she should be observed at least at hourly intervals; that she should access Listeners and Samaritans; that she should be referred to Carats and Psychology and that she should continue with her detoxification programme. A nurse saw the woman on 29 April and made the following recommendations: that she should be located in C4, that she should be located in a single cell, that she should access befrienders (i.e., Listeners), staff support and Carats and that she should be observed at “regular” intervals. The nurse had noted that the woman was not currently expressing suicidal ideation and that she had no intention of killing herself. The doctor who saw the woman (also on 29 April) reiterated that she was not assessed as being suicidal at that time.

26. Despite the recommendation made by the woman’s unit manager (at 1930 hours on 28 April) that she should be observed at hourly intervals, the first entry was made at 2100 hours (i.e., ninety minutes after this instruction was given). *During the night of 28-29 April, observations were made mainly at hourly intervals, although they were less frequent (and not in accordance with the instruction given by the unit manager) during the day of 29 April.*

27. An entry at 1015 hours on 1 May states that the woman was to be moved into dormitory accommodation (at her own request).

28. *The 72-hour review of the woman’s F2052SH took place at 1020 hours on 1 May (i.e., approximately 12 hours late). The review was attended by an officer and a Senior Officer and was not, therefore, multi-disciplinary.* The summary of the review noted that the woman was currently settled, although she was still distressed about having had no contact with her mother and brother. It was also noted that she was to be located in a dormitory later that day. The support plan stated that she should be encouraged “to communicate with staff and ask for help if she needs it”, that she should access Listeners/Samaritans and that she should work with psychology. *No level of observation was set at this review.*

29. Entries in the woman’s F2052SH during the morning of 3 May note that she complained of stomach pain; she spoke with the midwife at 0930 hours who advised her to attend outside hospital. At 1030 hours the woman was collected to attend the hospital. An entry at 1400 hours notes that, whilst in the hospital, the woman became

upset when she was told that it was likely her baby had died; this was confirmed at 2020 hours. Subsequent entries document the woman's upset and distress at the loss of her baby.

30. The woman was returned to HMP Holloway at 1112 hours on 5 May. According to the first entry in her F2052SH, the woman was "in good spirits and says she is glad to be back. But states she wants a single [cell]". Subsequent entries note that she was concerned that, if she were placed in dormitory accommodation, "she will be upsetting the others". The completing member of staff apparently called a Senior Officer and advised them not to place her in a single cell. However, after a lengthy conversation, the Principal Officer did place the woman in a single room next to the wing office, and had advised staff to observe her at fifteen-minute intervals during the lunchtime period. Consequently, entries were made in her F2052SH at the following intervals: 1240 hours, 1250 hours and 1305 hours. *However the next entry was made at 1330 hours (i.e., after a period of twenty-five minutes).*

31. An entry by the Chaplain (at 1500 hours on 5 May) notes that the woman continued to be shocked. The Chaplain contacted the hospital Chaplaincy and agreed to liaise with them regarding the woman's Waite's baby's funeral. The chaplain suggested that the woman consider bereavement counselling at a later date.

32. An entry at 1655 hours states that the woman had expressed no intent to harm herself and that she was looking forward to her sister's visit the following Sunday. A subsequent entry (at 1140 hours on 6 May) notes that the woman was in pain (physical and emotional) and that she had not found her discussion with the chaplain particularly helpful. At 1320 hours on 6 May, staff found the woman sitting behind her mattress on the floor of her cell. She was apparently distressed because she could not find the photograph of her child's scan. At 1520 hours she was found sitting on the windowsill of her cell with sheeting wrapped around her neck. Assistance was called, staff entered the cell and cut the ligature from around her neck.

No multi-disciplinary case review was held following this incident; this is a matter for particular concern given the woman's recent experiences. However, a member of Holloway's Mental Health Team attended to the woman. The member of the Outreach Mental Health Team entry notes that the woman had agreed to go to Holloway's in-

patient healthcare facility (C1), although she was concerned about sharing a room, “as she gets paranoid”.

33. The woman subsequently moved to C1 shortly after this incident, although the time was not noted in her F2052SH. *Having agreed that she would go into shared accommodation, the woman was placed in a dormitory alone.*

34. An entry was made in the woman’s F2052SH at 1610 hours. Subsequent entries were as follows:

2010 hours, 2140 hours, 2200 hours, 2300 hours, 2400 hours, 0044 hours, 0155 hours, 0300 hours, 0400 hours, 0500 hours, 0600 hours, 0650 hours, 0730 hours.

The woman was, therefore, observed at roughly hourly intervals. Following a discussion with the Senior Investigating Officer it appears that the woman’s level of observation was increased to hourly following her admission to C1, as part of a routine procedure. *However, this increased level of observation was not noted in her F2052SH. Neither is there any documented observation of the woman between 1610 hours and 2010 hours – a period of 4 hours.*

35. A period of 43 minutes elapsed between the woman’s observation at 0730 hours (when she was seen sitting on her bed) and when she was found suspended from a ligature – at 0813 hours.

36. The woman’s F2052SH gives no clear specification on the frequency with which she should have been observed. Page 2 of the document (completed by the Unit Manager on 28 April 2004) states that she should have been observed at hourly intervals. Page 5 (completed on 29 April 2004) states that that she should be observed at “regular” intervals. *The case review (conducted on 1 May) does not specify any level of observation.*

Summary

As outlined above, a number of issues have been identified with regards to the management of the woman’s F2052SH and, therefore, Holloway’s adherence to Prison

Service Orders relating to suicide prevention and the management of self-injury. The main issues identified are as follows:

- Observation levels were not always set, either by initiating members of staff, Unit Managers or Healthcare Staff.
- Healthcare staff have (on Page 5 of both the woman's F2052SHs) stated that she should be observed at "routine" or "regular" intervals. Such terminology is subjective and, therefore, likely to be interpreted by some staff differently from others. Healthcare staff should be more specific in this regard.
- When levels of observation were set (by healthcare or other staff) they were not always adhered to. When observations were conducted in a timely fashion, there is little evidence of them being anything other than observations (rather than interactions).
- Observations that took place at night were (mostly) carried out at hourly or half-hourly intervals and were, therefore, predictable.
- There is little evidence of night staff reading prisoner's F2052SH support plans in order to ascertain the level of observation set.
- Entries in the woman's first F2052SH state that, at one stage, she was located in a 'safer' cell. However, Holloway has no safer cells. It is an issue for concern that staff may perceive a non-safer cell to be a 'safer' cell in that it may provide a false sense of security.
- During her time in custody, the woman displayed suicidal behaviours (i.e., intent, self-injury or suicide attempts) on at least eighteen separate occasions. These incidents were not followed by multi-disciplinary case reviews.
- Following her return to Holloway (after the loss of her child) no review of the woman's F2052SH took place, nor was her level of observation reconsidered.

- Reviews of the woman's F2052SH were, on several occasions, attended by only one discipline of staff.
- The woman's support plans were, on occasion, vague and unspecific.
- There is little evidence (in the summaries of the woman's F2052SH reviews) that the different elements of the support plans devised at previous reviews were actually implemented and, if so, whether or not the woman found them in any way effective.
- Management checks, although frequent, very rarely assessed the quality of the F2052SH itself and whether or not it complied with Prison Service requirements. Often comments in the F2052SHs state nothing other than "management check" and do not (on the whole) assess frequency, quality or appropriateness of entries, frequency and/or relevancy of support plans and their implementation (or otherwise).
- The woman was, throughout the majority of her time at Holloway, located in a single cell. The reason for this is not documented. Current instructions recommend that prisoners identified as being at increased risk of suicide or self-injury are located in shared accommodation wherever possible.
- Very few of the incidents of self-injury/attempted suicide or noose/ligature making noted in the various documentation sourced were recorded on the Prison Service's Incident Reporting System.

A number of recommendations arising from the analysis of the woman's F2052SH are contained in the review of HMP Holloway's Suicide Prevention Procedures, as commissioned by the Area Manager for London

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Review of Clinical Management of the woman's Substance Misuse

The following section is a report by the Nurse Consultant on Substance Misuse, Women's Team, HM Prison Service, which was commissioned to identify HMP Holloway's compliance with current Prison Service Orders in regard to the woman's substance misuse treatment whilst she was in custody.

Introduction

The woman –

This is a report on the clinical management of the woman's substance misuse, provided at Holloway prison between 1/3/04 and 7/5/04, prepared at the request of the SIO, to assist with the investigation of the death in custody of the above named.

Findings

The woman was received into prison from court on the 1st March 2004, charged with attempted burglary (x3) and criminal attempts/damage, and being identified in reception as a drug user is located on the detox unit for stabilisation of her withdrawal in line with women's prisons protocols.

A suicide warning is sent by the woman's solicitors upon her arrival and a F2052SH is opened.

The woman's reception health screen reports that she was in receipt of a Methadone prescription from her GP, but that she is also currently using drugs, although there are no details as to what else she is using. It is recorded that she smokes 20-30 cigarettes daily. Her past drug use is noted as Heroin (IV) Crack (smokes) and the Benzodiazepines – Temazepam, Diazepam and Rivotril. She has shared needles in the past.

The woman was not sure of her last menstrual period, but believed herself to be pregnant upon arrival and this was later confirmed by a positive pregnancy test result. A previous T.O.P. is recorded, as is a cervical smear carried out in November 2003, but the results of this were not known.

This was not the woman's first time in prison, but she was noted as being anxious and withdrawn during her admission assessment, and she reported feeling suicidal, with thoughts of self-harm. She also gave a past history of self-harm in 2003 when she cut her arm and took an overdose. A psychiatric history is also recorded with Chlorpromazine being prescribed.

Blood pressure is recorded as 112/65 and pulse 96 and is the only recorded observation in the records.

The medical assessment in reception adds to the above estimating the pregnancy at two months gestation, acknowledging the open F2052SH, and confirming the dose of Methadone at 35mgs daily.

The admission urine test result is recorded in the medical records as per PSO 3550, and gives positive results for Morphine, Methadone, Benzodiazepines, and Cocaine, and negative results for Amphetamines and Cannabis. There is no evidence of this information having been being passed to the midwives, nor is there a copy of the notification to the probation department, both of which are requirements of the women's prison's protocol for the management of pregnant drug users. Urinalysis does not reveal any abnormalities.

Upon admission to the detox unit the woman is stabilised on Methadone, and a slow benzodiazepine withdrawal is started, both of which comply with the protocols for the management of pregnant drug using women in prison, which in accordance with PSO 3550 have been developed with approval from the local obstetrician, and local addiction consultant psychiatrist.

The woman's benzodiazepine reduction regime reduced by 2mg weekly and at the time of her death was just 2mg daily. Her overall Methadone regime had stabilised at 30mg daily, and was reduced in the mid-trimester by 2mg per week, achieving a total reduction of 4mg, which is again considered safe practice in the management of pregnant drug users, and complies with agreed protocols.

There is no evidence of a repeat urine drug screen on day 3, (a negative result being required before transfer to a residential location) nor any evidence thereafter that the twice weekly urine drug screens required as part of the management of these women were undertaken. There are two entries from the observation book, which state that the woman was thought to be involved in drug dealing on the unit.

From admission to the time of her death there are incidents of self harm recorded repeatedly, and on 3rd March it is noted that the woman was “hearing voices which tell her the devil has taken her over”. In addition to this the pregnancy, which the woman was initially wanted terminated was a result of a rape, and she is thought to be suffering from a drug induced psychosis on 15/3/04. She is prescribed Chlorpromazine in varying doses, and seen by the CMHT on 18/3/04, when it is also noted that she had been referred to the Henderson unit.

Apart from her pregnancy needs with regard to substance misuse, the woman also had mental health needs, which would have indicated a “dual diagnosis”. There is no evidence of joint care planning between the mental health and substance misuse teams. The decision to “fit” the woman for cellular confinement despite her pregnancy, early stabilisation on methadone maintenance, mental health problems, self harming behaviour, and an open F2052SH does not appear to have been a multidisciplinary decision.

There are several brief prescriptions for Metoclopramide and Prochlorperazine, but no supporting entries in the IMR to explain what the vomiting/nausea was attributed to. A productive cough is treated with Amoxycillin and Paracetamol on 31st March.

The woman first complained of vaginal bleeding whilst on the detox unit on 5th March, and again on 6th April. On 13th April she complained of abdominal pain and backache, and was found to be suffering from Chlamydia on 15/4/04 for which she was treated with an antibiotic. On 3rd May further abdominal pains are reported, and the woman then miscarried the following day.

Upon return to prison the woman is naturally very distressed, and it is recorded that she blamed herself for the loss of her baby. She was admitted to C1 (In-patient

healthcare unit) following further self-harm attempts and was found at 08.13 hours on 7th May suspended by a ligature. She died on 8th May 2004.

Discussion/Comments

PSO 3550 (Clinical Services for Substance Misusers) – The overall prescribing regimes used for the woman's substance misuse problems was managed in accordance with women's prisons protocols, and therefore complied with the above standard. There is therefore no reason to believe that this treatment plan contributed in any way to the miscarriage. The woman was asked to sign a disclaimer with regard to the rate of reduction, but in reality this was not necessary, as she was complying with medical advice.

Observations – Upon arrival a blood pressure reading is recorded along with a baseline pulse rate. This is the only recordable observation in any of the medical/nursing records that I have examined. PSO 3550 requires as an absolute minimum, that these observations are recorded for at least the first 72 hours, along with withdrawal monitoring, and there appears to be no records of any of this care being undertaken at all. **This part of the woman's care therefore fails to meet the required prison service standard.**

Urine testing – The admission urine test was undertaken upon arrival, and the result entered in the IMR which complies with PSO 3550.

The urine test results for all pregnant women are supposed to be passed to the midwives – **there is no evidence that this was done**, although it may have been and a copy not then kept in the medical records.

The women's prisons protocol for the management of pregnant women requires a repeat urine drug screen to be undertaken on day 3 of admission, to ensure illicit drug use has stopped. A negative result is required before the patient is transferred from the detox unit, and as there is no evidence that this was undertaken this is a failure to meet the standard of the agreed protocol.

Twice weekly urine drug screening (medically confidential) is then a requirement to monitor for any additional illicit drug use. There is no evidence of this being

undertaken, and is **therefore again a failure to comply with the agreed care** for these women. The results of these urine tests are supposed to be entered in both the patient hand held antenatal records and the detox care plan.

There is security information on two occasions that the woman was thought to be involved in drug dealing on the unit. **Was this information passed to the healthcare staff?** It should have resulted in the patient's methadone being withheld and urine tested to ensure that there was no additional drug use, before the medication was given. **There is no evidence of this taking place.**

Probation referral – Following a positive urine drug screen a referral to probation should be made, and there is no entry or copy of the referral form in the IMR to confirm that this happened. **This may just be a failure of record keeping, or it may have been an omission during the assessment process.**

Dual Diagnosis – The woman had both mental health and substance misuse needs, and yet doesn't appear to have been seen by the CMHT until 18/3/04. There is no evidence of any joint care planning, and her mental health needs were not considered in regard to her substance misuse care. *(They may not have differed, but joint planning and consultation should be evidenced.)*

On 2nd April the woman is fitted for cellular confinement, despite her pregnancy, mental state and being on an open F2052SH. (the Suicide and Self Injury Prevention Consultant will comment further) There is no evidence that CC was ever awarded, but it is of concern that the woman was considered fit to cope with this.

Vomiting – There are several brief prescriptions for anti-emetics, but no account in the IMR of why these were prescribed. It may have been pregnancy related, but could have indicated withdrawal.

Return to prison after miscarriage – Naturally distressed by losing her baby, it is clearly documented that the woman blamed herself for the miscarriage, even though she had complied with a safe methadone and benzodiazepine reduction regime, and the pregnancy had shown signs of being unstable from an early date. It is unclear as to exactly what she may have understood from the advice she was given regarding her

methadone prescription, and **raises the question of whether or not she used additional illicit drugs during her time in Holloway**, which could have caused withdrawal and distress to the baby, and could therefore have contributed to the premature ending of the pregnancy.

Care plans – Upon leaving the detox unit, the front sheet of the “extended methadone regime” care plan is completed, but this is the only nursing record in evidence. There would appear to be no contemporaneous nursing records monitoring the woman’s care beyond the detox unit.

Conclusions

The stabilisation and reduction regimes prescribed were safe and in accordance with agreed protocols, and thus PSO 3550, and would not have contributed to the miscarriage.

The overall monitoring of the woman’s progress with regard to withdrawal, and possible illicit use both of which could have affected the pregnancy were apparently lacking.

Recommendations

Observations, including TPR, BP and withdrawal monitoring should be undertaken for all women upon admission to the detoxification unit, for a minimum of the first 72 hours in accordance with PSO 3550.

Clinical drug screen urine testing must be undertaken on day three for all pregnant drug users, and a negative result achieved before transfer to a residential location.

Clinical drug screen urine testing must be undertaken twice weekly for all pregnant drug users throughout their pregnancy, in accordance with agreed women’s prisons protocols. The results of these tests must be entered in both the nursing care plan, and the hand held antenatal records.

When security information regarding possible illicit drug use/dealing is known, and the patient is in receipt of a methadone maintenance prescription, this information must be shared with healthcare staff, who in accordance with agreed protocols must test the

patient's urine, and observe for other signs of intoxication before any methadone is given.

Record keeping needs to be urgently reviewed.

Joint assessment and care planning between the mental health team and the substance misuse team needs to be evidenced.

A review of practice with regard to fitting for cellular confinement should be undertaken with advice from the Suicide/Self Injury Prevention Consultant.

This report is written with my having had access to the medical records, but not with the benefit of being able to discuss the above care with any individual healthcare staff, and it is possible that some of the care apparently omitted, was actually provided, and either not recorded, or recorded elsewhere. I should be happy to re-visit this report if any additional information becomes available.

Nurse Consultant

Substance Misuse

HMPS Women's Team

Clinical Review of the woman's care during period of custody

The following section is a report by the Lead Consultant Psychiatrist in Substance Misuse for a Mental Health & Social Care Trust, which was commissioned to identify the standard of medical care given to the woman whilst in custody at HMP Holloway.

Introduction

I, am a registered medical practitioner, a member of the Royal College of Psychiatrists (UK) and the Society for the Study of Addiction. I am recognised by the General Medical Council as being a specialist in general adult psychiatry and in the sub-speciality of substance misuse. I work as Lead Consultant Psychiatrist in Substance Misuse for the Mental Health & Social Care Trust. I have worked as a psychiatrist since 1985 and as a specialist in substance misuse since 1991. I am recognised under section 12 of the Mental Health Act (1983).

Terms of Reference

I have been asked by the Clinical Reviewer of the Primary Care Trust to provide an independent clinical review into the circumstances surrounding the death of the woman who died. The woman was certified dead at the hospital on the 08 May 2004 after she attempted to hang herself at HMP Holloway on the 07 May 2004. As a psychiatrist and drug addiction specialist, I will be focusing my review on my areas of clinical expertise.

Background

In preparing this report I have met with the senior investigating officer and a Primary Care Trust representative at Holloway Prison on 28.5.04. We discussed the case of the woman and went through her case notes and the chronology of events from the woman's remand to Holloway on 01 March 2004 to her death at the hospital on 08 May 2004. I have read through her health records, drug charts, first reception health screen, medical notes, nursing notes, CARAT assessment, and the two F2052SH records (07.3.04 to 20.4.04 and 28.4.04 to 7.5.04).

Review

In this report I propose to address the medical management that the woman received at various points during her remand at Holloway.

Drug Addiction Management.

The Health Screen at First Reception was completed on 01.03.04. This is a standard screening instrument covering physical health, drug/alcohol history, gynaecology, obstetrics and mental health. In the section on drug/alcohol history the woman was identified as ever having used heroin (i.v. - intravenously), crack, benzodiazepines and cigarettes. She was identified as a current user. However, the type and amount of drugs that she was using prior to remand are not recorded. This information would have been useful in beginning to assess her severity of dependence on heroin, which in turn would have influenced the decision as to how much Methadone she might need.

The Brief Medical Screening at Reception on 01.03.04 again identified the woman as having a history of heroin, crack, Diazepam and nicotine use. It also states that she was taking Methadone 35mg daily, although the record does not say who was prescribing this.

A urine drug screen was undertaken at reception, which confirmed that she had recently used cocaine, opiates, Methadone and benzodiazepines.

A Detoxification Care Plan was completed on the 01.03.04 and reviewed on the 21.03.04. She was prescribed 10mg of Methadone on the 01.03.04, 20mg on 02.03.04 and 30mg on 03.03.04. Thereafter she stayed on 30mg of Methadone daily until 24.04.04. It would have been helpful for the admitting doctor to have confirmed whether the woman was actually being prescribed 35mg Methadone daily, as if this were the case, it would have been normal practice to continue to prescribe at the same level instead of building up the dose from 10mg on day one to 30mg on day three. If the woman had indeed been taking 35mg of Methadone prior to remand and was put on 10mg on the 01.03.04, she may have experienced some opiate withdrawal symptoms over the next 24 hours, until the dose was increased. Withdrawal symptoms

can cause contractions of the smooth muscle of the uterus and foetal distress. However, as Methadone is a very long-acting drug, if she had taken 35mg Methadone on the 29.2.04, it would still have been having an effect on the 01.03.04. So although she was given smaller doses than she may have been accustomed to taking over the next 2 days, it is unlikely that she would have developed severe opiate withdrawal symptoms. The dose could have been confirmed by contacting the GP or the dispensing pharmacy.

The woman was then stabilised on 30mg Methadone daily. She subsequently requested to start reducing the dose of the Methadone because she was concerned about her baby developing withdrawal symptoms after birth. On the 09.04.04 she signed a Detoxification Disclaimer saying that she wanted to reduce her Methadone by 2mg per week.

During pregnancy, women are either maintained on Methadone until delivery or an attempt is made to reduce the dose prior to delivery. Both options are recognised as appropriate clinical management. Maintenance tends to be chosen when there is a risk that by reducing the dose of Methadone, the woman will relapse into using illicit heroin. Slow reduction tends to be chosen when the woman is motivated to try to reduce the dose and does not relapse when this happens. The advantage of reducing the dose of Methadone is that if the woman is able to get the dose down to 15mg or less, the risk of the baby developing withdrawal symptoms is significantly reduced. Therefore, the woman's request to reduce the dose of Methadone and the doctor's agreement to do this is clinically sound. Documentation to say that this discussion had taken place is useful. The Detoxification Disclaimer document suggests that such a discussion took place, however, it implies that the doctor felt that the Methadone should be maintained whilst the patient wanted to reduce. The rate of reduction of 2mg every 2 weeks is an appropriate and safe level of reduction.

By the time of the woman's stillbirth, the dose had only been reduced by 4mg down to 26mg. I think it is unlikely that this reduction was responsible for the miscarriage.

In view of her history of benzodiazepine use and the urine screen positive for benzodiazepines, the woman was also started on a Diazepam detoxification regime. She was started on 20mg daily on 01.03.04 and this was gradually reduced by 2mg a

week until the detoxification was completed on 6.5.04. This is a fairly standard and safe rate of reduction and should not have caused any significant complications.

The woman was referred to the CARAT team (Care Assessment Referral and Throughcare) who work with inmates who have drug problems. Their remit is to act as a link between the prison and drug treatment services in the community. The CARAT team assessed the woman on the 08.03.04 and contacted her local drug treatment service so as to initiate the process of referring the woman for residential detoxification and rehabilitation treatment. Their notes confirm that they spoke to the woman's pre-remand link worker from the agency known as Revolving Doors and made a referral for funding for residential treatment to her local drug service on the 04.05.04.

Mental Health.

The First Reception Health Screen completed on the 01.03.04 identified that the woman suffered from "psychosis" and "manic depression", that she had inflicted injuries to her left forearm in 2003 and had taken an overdose in December 2003. She responded "yes" to the questions "Do you feel like hurting yourself at the moment?" and "Are you suicidal?". She was also noted to be "excessively withdrawn or depressed" and "excessively anxious".

The Brief Medical Screening at Reception also identified this psychiatric history of "psychosis", "manic depression", "overdose" and "self-harm". As a consequence the doctor requested that a F2052SH be opened.

In the Reception Screen, she also stated that she was taking Chlorpromazine – a neuroleptic drug used in the treatment of psychotic illnesses. Chlorpromazine 100mg daily was written up on her drug chart on the 05.03.04 and increased to 150mg daily on the 22.03.04. Although the case-notes record that she was known to a hospital and had had an admission to a ward, there is no record of contact having been made either with the hospital or with her GP to confirm this admission, her psychiatric diagnosis and whether she should have been taking any other psychiatric medication.

If a patient gives a history of manic depression or psychosis, it would be good practice to try to confirm this. It may not be possible for this to happen at the initial screening phase but it would have been appropriate for the woman to have been referred to the

psychiatric in-reach team (the Department / Medical Staff responsible for healthcare of prisoners suffering from mental health problems) at this point, so that a more detailed psychiatric assessment and risk assessment could have taken place. The first record of the psychiatric team assessing the woman is on the 18.03.04, but even then a full psychiatric history and mental state examination do not seem to have been undertaken.

Monitoring of risk for self harm.

The woman had a F2052SH opened on 01.03.04 and this stayed open until 20.04.04. A second F2052SH was opened on 28.40.04 and remained open until the woman's death.

During this time there were a whole series of threats and attempts at self harm: 02.03.04 – cut left arm, 02.03.04 – found suspended by a sheet from the window, 04.03.04 – wanting to kill self, 04.03.04 – attempting to hang self, 18.03.04 – wanting to hang self, 18.03.04 – seen by psychiatric team and expressed active suicidal ideas, 22.03.04 – cut left arm, 22.03.04 – cut right arm, 02.04.04 barricaded self in room and seen making a ligature, 28.4.04 – cut wrist, 04.05.04 – threatened to smash lamp and cut self, 06.05.04 – sitting on window sill with sheeting around her neck.

In addition to these records of self-harm, the woman was also reported to be hearing voices on the 03.03.04. A comprehensive risk assessment was conducted on the 06.05.04 when the woman was admitted to the Healthcare Unit – however, the risk assessment section was not completed. The second F2052SH stated that observations should be “at least once every hour” and this instruction was largely followed. A Health Care Assessment on the 29.04.04 changed the level of observation to “regular obs” but the precise frequency of these is not stated. Following her miscarriage at the hospital, the woman returned to Holloway on the morning of the 05.05.04. There does not seem to have been a re-assessment of her risk of self-harm and no change appears to have been made to the frequency of the observations. In view of her psychiatric history and her history of self-harm during her stay at Holloway, it would have been advisable for the woman to have been observed more frequently and to have had a further psychiatric assessment.

The woman was observed with sheeting around her neck at 15.20PM on 06.05.04 and was later transferred to C1 the hospital ward. Apart from between the hours 16.10PM and 20.10PM on the 06.05.04, she was seen at roughly hourly intervals until she was found at 8.13AM on the 07.05.04 with a ligature around her neck, suspended from a window hinge.

It is easy with the benefit of hindsight to say that the woman should have been observed more frequently, although there was only a lapse of 43 minutes between the woman last being seen alive to her being found hanging. However, as the preceding suicide attempt followed on from the miscarriage, it should at least have triggered a review of the supervision arrangements.

Management of Pregnancy and Miscarriage.

As a psychiatrist I do not feel in a position to comment on the management of the woman's pregnancy and miscarriage. Suffice to say that the woman's pregnancy was identified at the initial screening.

Emergency Management of Incident.

As a psychiatrist I do not feel that I can offer expert advice on the CPR (cardio-pulmonary resuscitation) administered by the team on C1 or of that continued by the ambulance staff when they arrived. My first question would be whether all staff involved in the incident have attended courses and refresher courses in CPR? There is a second question as to why the ambulance personnel who arrived at the scene were not paramedics?

Recommendations

As the woman reported that she was taking Methadone 35mg on admission to prison, it would have been helpful to have confirmed this by contacting the GP, the prescribing doctor or the dispensing pharmacy. If this self report were true, then the woman could have been immediately stabilised on 35mg Methadone daily instead of starting her on a dose of 10mg and building it up to 30mg over 3 days. In general, patients admitted to prison who are being prescribed Methadone on the outside, should have their dose confirmed and continued, where it is safe to do so.

Also on admission to HMP Holloway the woman gave a history of manic depression, psychosis, self-harm, a previous admission to a psychiatric hospital and named the ward at the hospital where she had been admitted. She also stated that she was being prescribed Chlorpromazine. In view of this psychiatric history, I feel that it would have been appropriate for the woman to have been immediately referred for a full psychiatric assessment by the psychiatric in-reach team, so that her psychiatric history, mental state and risk assessment could have been evaluated. I do not know what the capacity is for the psychiatric in-reach team to rapidly assess all inmates who have been admitted to prison with a significant psychiatric history, but it would seem reasonable to endeavour to do so.

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Midwifery Officer's Clinical Review

The following section is a report by the LSA Midwifery Officer of the Primary Care Trust, which was commissioned by the Investigation Team to identify the standard of medical care given to the woman during her period of custody at HMP Holloway. This report primarily focuses on the woman's pregnancy and miscarriage.

Background

This investigation concerns the death of the woman, age 29 years. The woman was in custody at HMP Holloway since 1st March 2004. She claimed to be pregnant following a rape by an unknown person. The woman was a persistent drug abuser giving a history of substance abuse since age 8 years that progressed to IV heroin, crack cocaine and other substances. During pregnancy her addiction was managed by prescribed methadone as she was participating in a detoxification programme, she was also taking largactyl for her psychotic illness.

Initially the woman was ambivalent about continuing with the pregnancy; she booked for termination and then decided to continue with the pregnancy.

The woman was identified by HMP as being at high risk of self-harm and therefore placed on the observation unit rather than the antenatal wing of the prison. Throughout her stay at HMP, both before and after the miscarriage, prison officers made twice-hourly observations of her well being. Despite the close observation she made several attempts to harm herself with glass and she was found to be making ligatures on two occasions.

A prompt referral was made to the prison drugs service (Carats) on the 2nd March following admission to HMP and an assessment was commenced on the 18th March, this assessment was concluded on the 24th April. During this period the psychologist noted that the woman was actively suicidal and wanted to hang herself. There is no evidence that this finding was communicated to the midwifery team.

The woman was continuously distressed by the lack of contact and support from her family, in particular awaiting visits from her mother that never materialised.

Process of Investigation

To undertake this investigation the following documents were scrutinised:

- HMP observation records
- Whittington Hospital notes
- CARAT notes
- Statements from health professionals

Previous history

A manic-depressive illness was previously diagnosed and treated at Hospital (date not documented). Substance misuse since the age of eight years was documented.

Antenatal Summary

Booked by midwife at hospital. At 16 weeks and 3 days pregnancy, dates confirmed by ultrasound scan at the hospital as the woman had no menstrual history for several years due to her misuse of drugs. An anomaly scan was performed at the hospital on 23rd April and this confirmed a gestation of 19 weeks. A midwife examined her again in the HMP antenatal clinic on the 26th April.

During the booking history taking, a scanty reference was made to the previous psychiatric history and admissions to the hospital and it was noted that referral to the prison psychology service was made by HMP. No reference was made to a history of self-harm. There is no evidence of communication with the psychiatric team at that hospital to elicit details of past admissions nor referral to a psychiatrist to agree a care plan for this pregnancy. The CARAT records state that the woman was treated at a psychiatric unit in September 2002.

On the 3rd May contractions commenced at 20 weeks and 4 days. Transferred to hospital where ultrasound scan revealed that an intrauterine death had occurred. The woman was pyrexial so IV antibiotics were commenced. She miscarried a male fetus spontaneously later that evening.

Postnatal summary

The woman was very distressed. She was nursed in a single room, IV fluids and antibiotics continued. On the 5th May she took her own discharge from hospital returning to HMP on oral antibiotics to be followed up by a Community Midwife who planned a visit two days later.

On 7th May a prison officer found the woman hanging in her dormitory which she occupied alone. She was transferred to hospital and died the following day in ICU.

Failures in clinical management

The most striking feature in this case is the failure of any of the professionals involved in the woman's custodial and medical care to make a referral to her Psychiatrist in the light of

- her past history together with her current pregnancy,
- loss & grief following miscarriage, history of self harm,
- drug abuse,
- social exclusion and
- lack of contact with her mother.

A number of opportunities were missed to initiate a multi professional 'care plan programme' for this vulnerable young woman who was a mother to be. It is not clear whether guidelines are in place at the hospital for managing pregnancies in the light of previous mental illness.

Key recommendations from the 1997-1999 confidential enquiries into maternal death (Why Women Die – Nice 2001. Chapter 11 deaths from psychiatric causes) appear not to have been implemented in this case. Particularly relevant is the recommendation that: 'the psychiatrist undertakes an assessment in the antenatal period and a management plan is instituted'; women with a past history of mental illness have a 1:2-3 chance of recurrence during or following pregnancy. This recommendation is further supported by those of the Confidential Enquiry into Suicides (www.doh.gov.uk/mental health safety first (12 points to a safer service).

HMP referred the woman to the prison psychology team; the initial assessment was protracted and there appeared to be no urgency about it. Even when recording 'high risk of suicide' a psychiatric opinion was not sought.

The booking history was cursory and did not meet the recommendation that 'enquiries about previous psychiatric history, its severity, care received and clinical presentation should be routinely made in a systematic and sensitive way at the antenatal booking clinic.' A similar opportunity for medical and midwifery staff to initiate such enquiry was missed at each contact including the postnatal period.

Interagency communication was another key area of failure. Each professional group acted in isolation from the others. HMP undertook eight reviews and these would have provided a good opportunity for exchange of information between the professional groups involved and the development of an individual care plan for the woman. Had a Psychiatrist been involved they may well have deemed a psychiatric ward a more suitable environment than prison for the woman and prescribed treatment accordingly.

Conclusion

There was a lack of communication and team working between the various agencies and as a result there was no multidisciplinary plan of care for this vulnerable young woman.

The lack of referral to a Psychiatrist was a serious omission by all agencies. Although there is no way of knowing if the outcome would have been different if she had been admitted to a psychiatric hospital, existing evidence from confidential enquiries into both maternal death and suicide by people with mental illness suggests that treatment as an inpatient should have at least have been considered.

It is strongly recommended that a 'Care Programme Approach' as outlined in the report on the confidential enquiry into suicides and recommended in the report on confidential enquiry into maternal death is implemented.

