LEARNING LESSONS BULLETIN NO. 2

DEATH IN CUSTODY REPORTS: FEMALE CASE STUDIES

The following summaries are based on PPO (Prisons and Probation Ombudsman) death in custody reports. The cases have been selected for this publication by Safer Custody and Offender Policy (SCOP), as they provide learning opportunities for establishments and may help them to improve their local policies and practices. This is a departure from the normal 'good practice' that appears in 'Safer Custody News'. It follows the lead of the Independent Police Complaints Commission, which recently began publishing a 'Learning the Lessons' bulletin which disseminates summaries from their reports to police forces and other bodies with constabulary powers.

Complete versions of PPO reports can be found on the Ombudsman's website – see the fatal incidents section: www.ppo.gov.uk/publications/fatal-incidents/index.html

CASE STUDY: ONE

A woman was remanded into prison custody following a night in a police cell. Whilst at the police station she was considered a potential risk of self harm due to her past record of suicide attempts. She was also withdrawing from drugs.

The prisoner was a mother of five children. Two of these had been adopted by the time she came into custody, one lived with the prisoner's parents and the other two were due to be adopted in the near future.

It was well known amongst prisoners and staff that her children had been taken into care, but no one was aware of how upset she was as a consequence. She did not appear depressed and gave staff no reason to be actively concerned about her mental wellbeing.

The prisoner had an introductory meeting with a CARATs worker and during this meeting told her that her reason for self referral was that her children were being put up for adoption the following week. A few days later the prisoner saw a prison social worker and asked her to contact her parents regarding the residential order for two of her children. In asking her to do this the prisoner did not mention the adoption hearing, nor did she indicate the message was urgent. The social worker did try to contact her parents, but there was no answer when she called. She did not try again.

Some days after this the prisoner was found hanging in her room. Despite attempts at resuscitation staff and paramedics were unable to revive her. Her family remain convinced that her depression and subsequent actions were heavily linked to the adoption of her children.

Key lesson: INFORMATION SHARING - key lesson is the need for relevant agencies to work together more closely in addressing the needs of women prisoners. By working together more closely it might be easier to identify and highlight when a prisoner might be in crisis. Women are particularly vulnerable and great emotional strain is placed upon them due to separation from family, especially children. Providing prison staff with information about imminent and difficult custody cases would allow for additional support mechanisms to be put in place.

CASE STUDY: TWO

A prisoner, who had started life as a male but had undergone gender reassignment surgery, joined an establishment's Therapeutic Community (TC). A TC offers group based therapeutic treatment in a community setting. Prisoners lead and take part in community meetings where any problems affecting the community are aired and conflicts are solved in a democratic way. Prisoners take part in small therapy groups where they are urged to look at the attitudes and feelings around their offending behaviour.

The prisoner had a history of self harm and was also judged to a threat to other prisoners and staff. She eventually left the TC of her own accord before being voted out as she had broken a TC rule about not engaging in relationships with fellow TC members.

She was transferred to another prison, but no reports detailing treatments and her experiences whilst on the TC were sent with her. An end of therapy report did not arrive at the receiving establishment until approximately two weeks later. This was due to a member of staff, who was not aware of the prisoners transfer, being on leave.

The prisoner continued to self harm and an ACCT was opened. She said that the therapy whilst she in the TC had generated a lot of painful memories. There was deterioration in her behaviour and attitude towards staff and it was decided that she should be segregated for reasons of good order and discipline.

She was discovered later that day with a ligature round her neck. Staff tried to resuscitate her but she died following transfer to outside hospital.

Key lesson: CONTINUITY OF CARE – key lesson is the need for the timely completion of an End of Therapy Report as detailed in PSO 2400 and the need for it to be transferred with a prisoner. The receiving establishment, in this case, had to send emails and telephone the previous establishment to ascertain the circumstances under which the prisoner left the TC. The PPO felt that there was insufficient handover from the TC, to the wing and then to the new establishment and made a recommendation about this. In response to this recommendation the TC team at the establishment have introduced an assessment proforma which is completed immediately a prisoner leaves. The assessment will be sent to wing officers and offender manager units until replaced by a fully completed End of Therapy report.

CASE STUDY THREE

A prisoner with a long history of drug abuse was discovered unconscious by an officer who was unlocking her in order to receive medication. She was cold to touch and staff were unable to rouse her.

A nurse heard staff shouting for assistance and went to the prisoner's room. An officer sent out a Code Blue alarm (this indicates that a prisoner has severe breathing difficulties and support is needed from healthcare and senior staff). Indications were that the prisoner was dead and resuscitation was not attempted. An attending Senior Officer radioed through to the communications room to ask for an ambulance to be summoned. The prisoner was pronounced dead by paramedics some time later.

During the PPO investigation it was difficult to ascertain the timings of events. This was not helped by the fact that the communications officer did not fill in the relevant page of the contingency action plan. His explanation for not doing so was that the plan is entitled 'Death in Custody' and is therefore only completed when the duty communications officer know the prisoner is dead.

Some inconsistency was also found regarding who should summon a response from the ambulance service. Staff considered that a Code Blue alarm should not automatically trigger a 999 call. They reasoned that there are many incidents of prisoners being found with ligatures around their necks, and healthcare and discipline staff said they were able to deal with the vast majority of these cases without assistance from paramedics.

Key lesson: CONTINGENCY PLANS – in this case the prisoner had been dead for some time. However, the delay in calling an ambulance could be critical in other circumstances. Contingency plans should allow for first officers on the scene to request the attendance of an ambulance if they consider it to be appropriate. This is in accordance with Department of Health guidelines. Governors should also remind all staff who work in the communications room of the purpose of contingency plans and the circumstances when these should be followed.

CASE STUDY FOUR

A female prisoner was recalled into custody, after her release from prison the previous year, as she had not complied with her licence conditions. She had returned to taking drugs after her release and had a long history of mental health problems. At the time of her recall she was under the care of a psychiatrist and community psychiatric nurse.

Shortly after her arrival she was seen by a member of the mental health in reach team (MHIT). They noted the medication she had been on in the community (which included a mood stabiliser). This was not a formal assessment and following the meeting the plan was to seek confirmation of her medication from her psychiatrist.

The prisoner began experiencing mood swings, and could be tearful and aggressive. An ACCT was opened. She also began to seriously self harm. Some three weeks after her arrival, nurses chased up details of her prescribed medication with her GP. This information had, in fact, been sent in by her psychiatrist the week before but it was not acted upon for another week.

Another seven days later the prisoner was discovered by staff hanging from a ligature attached to the window.

The PPO, and the prisoner's family, were concerned that it took so long for this information about medication to be chased up and that the information when it was received did not seem to be placed in the clinical records. Even when the prisoner did start taking this medication again it would have taken time to work effectively.

Key lesson: INFORMATION SHARING AND MANAGEMENT – As per PSO 3050 'Continuity of Healthcare for Prisoners', efforts should be made to retrieve information from the prisoner's GP and/or other relevant services. The PPO recommended that information regarding existing prescribed medication should be requested within 24 hours of a prisoner's reception and follow-up action taken if the information is not received promptly. When information is received, appropriate action should be taken without delay.

INQUEST VERDICTS AND CORONERS REPORTS

There were seven inquests held into the deaths in custody of women between March and May this year. There are lessons to be learned from all of these cases.

A number of different issues were raised via the inquest verdict or the Coroners Rule 43 report. Rule 43 gives Coroners the power to make reports to a person or organisation where he/she believes that action should be taken to prevent future deaths. From 17 July, a new duty was placed on organisations to respond to these reports; reports and responses will be shared with bereaved families via the Coroner. The MOJ intends to issue a regular bulletin so information on the types of matters that are being reported and the action taken as a result will be publicly available. The first bulletin will be published on the MOJ website in 2009.

KEY ISSUES RAISED AT THE INQUESTS WERE:

- Lack of communication and information sharing between staff, particularly across disciplines;
- Identification of 'triggers' for self harm (e.g. court appearances);
- Insufficient healthcare resources, specifically within the mental health teams;
- Inadequate completion of documentation;
- Prison not an appropriate place for those with mental health problems;
- No infrastructure in the Forensic Mental Health Service for women with the specific issues of the prisoner concerned;
- Lack of training in resuscitation techniques, first aid and use of defibrillators;
- Detoxification management.

We have selected one particular death as a case study. The rest of the inquest verdicts and details of the cases will be placed on the Prison Service Intranet or available from SCOP (for contact details, see end of bulletin).

CASE STUDY: FIVE

A prisoner was received in to HMP/YOI New Hall on 9 July 2003 charged with arson with intent to endanger life (the offence took place in her own home and it was believed that the fire was an act of self-harm). She was 19 years old and a single mother of child aged 18 months (in the care of Social Services).

She had a long history of self-harm in the community and had been receiving support from a Community Psychiatric Nurse. She was not considered to be mentally ill, but it was believed that she had a personality disorder.

On the basis of her history, court escort services had opened a F2052SH prior to her arrival at New Hall. Additionally, Derbyshire Probation Service contacted the Governor to highlight that she was at high risk of self-harm. Ms D remained on the F2052SH throughout her time at New Hall. Some 90 incidents of self-harm were logged during the 130 days she was there.

On 19 November 2003, the prisoner was found in her single cell on normal location, unconscious with a ligature tied round her neck. Resuscitation was attempted and shortly after she was taken to an outside hospital and placed on life support. Four days later, the decision was taken to switch off the life support system, and on 24 November 2003 she passed away.

The inquest concluded on 5 February 2008. The verdict was:

"On or around 11.40am on the 19th November 2003 in New Hall Prison Wakefield, a prisoner asphyxiated herself by ligature. This resulted in her ultimate death in Pinderfields Hospital, Wakefield at 11.35am on the 24th November 2003.

Traumatic life experiences including mental health and physical abuse in early childhood, coupled with an unstable upbringing and complete lack of emotional support. Prison was not an appropriate place on view of the prisoner's diagnosis. There appears to be no infrastructure in the Forensic Mental Health Service for people with her problems".

RULE 43 LETTER

The Coroner wrote to the Secretary of State as follows:

"The prisoner was received into prison on 9th July 2003 charged with arson with intent to endanger life. This arose from the prisoner having tried to set fire to herself by way of an attempt at suicide, but this caused her accommodation to catch fire. Her motive was not that of destruction or deliberate fire raising. At the time the prisoner was aged 19, she was a single mother of a baby boy aged 18 months. She had complex mental health problems. At the time her child was under the care of Derbyshire Social Services.

She had a long history of self harm and at the time of the offence was receiving support herself from social workers, and a community psychiatric nurse. The prisoner was suffering from a personality disorder; she was always regarded as being at high risk of self harm, and there had had been countless occasions when she had cut herself, attempted ligature strangulation, set herself alight, she had

inserted objects into her body through wounds, and had taken several overdoses of tablets.

For the whole of the time that she was at New Hall Prison she was subject to the Form self-harm monitoring procedure. I heard evidence that in the 130 days that the prisoner was in prison there were 90 incidents of self-harm. On two occasions she had to be transferred to an outside hospital for treatment. Notwithstanding this she was popular with both staff and fellow prisoners, who had a considerable regards and affection for her.

The prisoner had been diagnosed prior to her admission to prison as having an emotionally unstable personality disorder. This raised issues as to whether or not she could be detained under the Mental Health Act 1983. This rationale for not detaining her was that it would only have been appropriate to detain her under Section 3 of that Act, as opposed to Section 2, which is for assessment. The only class of mental disorder from which she was suffering was "psychopathic disorder", and to be detained under section 3 would be necessary to show that she was treatable. According to the psychiatrists responsible for her care this criteria was not met. It was thought that she might benefit from psychotherapy, but was not ready to reside in a therapeutic community as she was taking medication, was too chaotic and her risk of self harm was too high. Notwithstanding this no suitable facility could be found.

The Inquest heard that the prisoner was at very high risk of killing herself, whether she was in Prison Health Care Centre or an ordinary location, or in psychiatric hospital in the community. Notwithstanding that her care in prison was regarded as satisfactory. It was abundantly clear that prison was not the appropriate place for a young lady with her complex problems, but because of her diagnosis of a psychopathic disorder there where no grounds for transferring her to hospital for treatment under Section 48 of the mental health Act 1983. The prisoner was typical of prisoners with mental disorder who politicians and those who campaign say should be in hospital rather than prison, yet there is no way of achieving this.

It must be that in a civilised society someone as severely mentally disordered as her should have been in the care of ordinary or forensic psychiatric services, and not in prison.

The point of my contacting both the Prison Service and Department of health is to urge, by virtue of this recommendation, that the two departments work together to achieve a situation where suitable, secure, therapeutic environments outside prison can be available for those like this prisoner, suffering from such disorders.

I am very much aware that this issue forms part of the Corston report of a review of women with particular vulnerabilities in the Criminal justice System".

Safer Custody and Offender Policy (SCOP) responded to the Coroner's letter on 4 April 2008. A separate response was sent by the Department of Health (DH). SCOP's response outlined the Government's support for Baroness Corston's independent review of women with particular vulnerabilities in the criminal justice system, published in March 2007, and briefly outlined progress to date in taking forward key recommendations made in the Corston report. It also explained that overall implementation of the Corston recommendations was being taken forward as part of the DH's newly developing 'Offender Health Strategy'. The letter stated:

"Included within the strategy will be a distinct pathway for women offenders, which will look at improvements in health provision throughout the criminal justice process as well as more generally in the community for women at risk of offending, and a specific work strand on court diversion in regard to women suspected of having a mental health problem. It is a priority to ensure that women have access to the right mental health services and treatment in the community so that mental health problems can be identified and responded to as early as possible and before the problems escalate."

Since SCOP's response was written, the government has issued a detailed six-month progress report titled "Delivering the Government Response to the Corston Report: A Progress Report on Meeting the Needs of Women with Particular Vulnerabilities in the Criminal Justice System" (published in June 2008). This progress report can found on the MOJ website: www.justice.gov.uk/docs/corston-progress-report.pdf

SCOP's letter to the Coroner also outlined other relevant developments, including:

- Substantial Government funding for the Together Women projects in the North West and Yorkshire & Humberside, which are designed to show how a co-ordinated multi-agency approach, using women's centres and key workers, can better address the multiple and complex needs of women in the community.
- Commissioning in December 2007 of an independent review by Lord Bradley, a former Minister of State at the Home Office, of diversion from custody, including courts and transfers from prison. Lord Bradley is now expected to report his findings in December 2008 to the Department of Health and the Ministry of Justice.

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