Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Ms Kirsty Walker a prisoner at HMP Bronzefield on 27 September 2015

A report by the Prisons and Probation Ombudsman
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Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Ms Kirsty Walker died in hospital on 27 September 2015 of a hypoxic brain injury, as a result of tying a ligature around her neck at HMP Bronzefield, two days earlier. She was 26 years old. I offer my condolences to Ms Walker's family and friends.

Ms Walker harmed herself prolifically in prison and managing this safely was a significant challenge. During her six months at Bronzefield, officers recorded 235 incidents of self-harm, 215 of them by tying ligatures around her neck to self-strangulate. I consider that much of the care Ms Walker received from individual staff was good but her overall care planning lacked coherence and consistency. Suicide and self-harm prevention procedures were not sufficiently multidisciplinary. In particular, there was insufficient involvement from the mental health team. Ultimately, despite some of the procedural frailties, I recognise that the nature and frequency of Ms Walker's self-harm, made it extremely difficult for prison staff to prevent her death.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **July 2016**

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Summary

Events

1. Ms Kirsty Walker had served a number of short sentences at HMP Bronzefield since 2009. On 24 March 2015 she was remanded to Bronzefield and on 6 May 2015, she was sentenced to 18 months imprisonment. Ms Walker had borderline personality disorder, alcohol and substance misuse problems and a history of depression. In the community her mental health was managed under the NHS Care Programme Approach (CPA) and this care was transferred to health services in prison.

2. Ms Walker was a prolific self-harmer in prison. Between 25 March and 25 September 2015 (185 days), she harmed herself on 235 occasions. On 215 of these, she tied strips of material around her neck tightly enough to stop her breathing. She cut or scratched herself 19 times and tried to set herself on fire once.

3. Ms Walker was managed under Prison Service suicide and self-harm prevention procedures (known as ACCT) throughout her time in Bronzefield. A mental health nurse was allocated as her care coordinator in prison but attended only one ACCT case review. Ms Walker had a single ACCT case manager until late August but after that, several different people chaired ACCT case reviews.

4. In the week before her death, Ms Walker had asked to move to a different houseblock. She told an officer that she was no longer friends with some women she had previously been close to, but now felt bullied by them. Three prisoners who had been good friends with Ms Walker said that she had confided in them, but they had not fallen out with her. The houseblock manager decided not to move Ms Walker and encouraged her to resolve her differences with the other women.

5. On 25 September 2016, an officer found Ms Walker unconscious in her cell with a strip of sheet tied around her neck and called a code blue emergency. Staff immediately began cardiopulmonary resuscitation. Paramedics arrived, found a faint pulse and took Ms Walker to hospital. Ms Walker did not recover and died on 27 September.

Findings

6. Ms Walker was a very challenging person to manage. Much of the care offered to her by individual staff was good. Nevertheless, there were some deficiencies in the management of ACCT procedures to support her. The investigation found that:

    - ACCT reviews were not sufficiently multidisciplinary. In particular, Ms Walker's designated care coordinator from the mental health team attended just one case review.
    - There was no consideration of whether to manage Ms Walker under enhanced case management procedures and there was no clear and consistent management plan.

- There was no clear ACCT careplan action to help reduce Ms Walker's risk and the plan did not reflect all decisions taken at case reviews.
- A decision to charge Ms Walker with a disciplinary offence if she damaged prison property to self-harm was not applied consistently and managers did not ensure that disciplinary action took into account Ms Walker's wellbeing.

7. The clinical reviewer concluded that, over her several periods of imprisonment, Bronzefield provided a good standard of mental healthcare to Ms Walker. However, we are concerned that the level of effort and engagement was not sustained during her final sentence.

8. We are satisfied that the decision not to move Ms Walker to a different houseblock in the week before her death was reasonable.

9. It does not appear that the act of self-harm on 25 September, which led to her death, was any different from the numerous previous occasions when Ms Walker had tied material tightly around her neck. Given the nature and frequency of Ms Walker's self-harm, she was always at high risk and it would have been extremely difficult for staff at the prison to have prevented her death.

Recommendations

- The Director and Head of Healthcare should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including:

    - Holding multi-disciplinary ACCT reviews with continuity of case management and involving all staff who can contribute to the care of a prisoner at risk.
    - Using the enhanced case review process when appropriate.
    - Setting effective caremap objectives which reflect decisions from reviews, are specific and meaningful, and which identify who is responsible for completing them and when they have been completed.

- The Head of Healthcare should ensure that prisoners subject to the Care Programme Approach have a documented therapeutic plan with clear objectives and that their care coordinator in the prison meets them regularly to update the plan and records all contact and concerns.

The Investigation Process

10. The investigator issued notices to staff and prisoners at HMP Bronzefield informing them of the investigation and asking anyone with relevant information to contact her. No one responded.

11. The investigator visited Bronzefield on 1 October 2015. She obtained copies of relevant extracts from Ms Walker's prison and medical records, CCTV, records of Ms Walker's telephone calls and listened to radio messages of 25 September.

12. The investigator interviewed eight members of staff and three prisoners at Bronzefield in October 2015 and January 2016. She spoke to three other members of staff by telephone.

13. NHS England commissioned a clinical reviewer to review Ms Walker's clinical care at the prison. The investigator and clinical reviewer spoke to one member of staff by telephone.

14. We informed HM Coroner for Surrey of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

15. One of the Ombudsman's family liaison officers contacted Ms Walker's mother and her sister to explain the investigation and to ask if they had any matters they wanted the investigation to consider. Ms Walker's sister asked for details of Ms Walker's last ACCT case review and caremap; how often she was checked and what they involved; why she was not in a safer cell, and whether she was seeing a mental health worker. Ms Walker's family received a copy of the draft report. Ms Walker's sister said she felt that Ms Walker had been let down by the people who were supposed to help her. She said she was especially concerned at the number of records that were missing and the number of apparent interactions with Ms Walker that were not recorded. Ms Walker's sister was especially concerned about Ms Walker's relationship with her mental health nurse. Ms Walker's sister did not identify any factual inaccuracies.

Background Information

HM Prison

16. HMP Bronzefield is a privately managed local prison for women in Surrey, run by Sodexo Justice Services. It holds up to 527 women. Cimarron UK provide GP services and the Central and North West London NHS Foundation Trust provide mental health services.

HM Inspectorate of Prisons

17. The report of the most recent inspection of Bronzefield in November 2015 has yet to be published. Some initial feedback from the inspection was that arrangements for healthcare staff to attend ACCT case reviews were not well planned and coordinated, although officers said they would attend when invited.

18. The previous inspection of HMP Bronzefield was in April 2013. Inspectors reported that the safer custody team was accessible and that staff provided some good care for high-risk cases. The quality of some of the suicide and self-harm monitoring procedures needed improvement. Reviews and care plans needed to focus more on individual needs and staff from other relevant disciplines were not always present at reviews. There was a range of resources and programmes to help women who self-harmed deal with their distress, including art, music, psychological therapy, and counselling.

Independent Monitoring Board

19. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to July 2015, the IMB was concerned about the number of prisoners with personality disorders or learning disabilities who were repeat offenders and believed prison was an inappropriate and expensive place for these women. The IMB considered that the quality of entries in ACCT documents was inconsistent.

Previous deaths at HMP Bronzefield

20. Ms Walker's was the first apparently self-inflicted death at Bronzefield. Seven women died of natural causes or other non-natural causes between 2005 and 2014. There were no significant similarities between the circumstances of Ms Walker's death and the other deaths.

Assessment, Care in Custody and Teamwork

21. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner.

22. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular multi-disciplinary review meetings involving the prisoner. As

part of the process, a caremap (plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the caremap have been completed.

23. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Care Programme Approach:

24. The Care Programme Approach (CPA) is an NHS system of delivering community mental health services to individuals diagnosed with a severe mental illness or other vulnerabilities such as a history of violence or self-harm. Someone who needs CPA support should have a formal written plan that outlines any risks and a CPA care coordinator to organise and review the plan.

Incentives and Earned Privileges (IEP) Scheme

25. Each prison has an Incentives and Earned Privileges scheme which aims to encourage and reward responsible behaviour, encourage sentenced prisoners to engage in activities designed to reduce the risk of re-offending and to help create a disciplined and safer environment for prisoners and staff. Under the scheme, prisoners can earn additional privileges such as extra visits, more time out of cell, the ability to earn more money in prison jobs and to wear their own clothes. There are four levels, entry, basic, standard and enhanced.

Key Events

26. On 24 March 2015, Ms Kirsty Walker was remanded to Bronzefield for breaching an anti-social behaviour order and stealing beer from a supermarket. She had served a number of short sentences in Bronzefield from 2009, and had been released from her most recent previous sentence less than a week before, on 18 March 2015. Ms Walker had borderline personality disorder (also known as emotionally unstable personality disorder), a history of depression and alcohol and substance misuse problems. In the community, her mental health was managed under the NHS Care Programme Approach. A prison GP continued her fortnightly depot injection of depixol (a depot injection slowly releases antipsychotic medication into the body over a number of weeks). Ms Walker appeared cheerful during her initial assessments and was given a single cell on Houseblock 2.

27. On 25 March, staff began ACCT procedures when Ms Walker tied a strip of sheet around her neck in her cell. During an assessment as part of the ACCT process, Ms Walker said she felt low about being back in prison, self-harmed when she was low and could not stop herself. She said that when she had tied the sheet around her neck she had intended to end her life. She said she was now feeling positive but that her mood changed quickly and she would not tell staff if she felt like harming herself again.

28. Ms Walker was a prolific self-harmer in prison, but said she did not harm herself in this way in the community. Staff said she did not offer any explanation or insight into her actions beyond saying that her mood dropped and she could not predict when this would happen. In the 185 days between 25 March and 25 September 2015, staff recorded 235 incidents of self-harm. Ms Walker cut or scratched herself 19 times and tried to set herself on fire once. On the remaining 215 occasions, she attempted to strangle herself by tying a strip of material around her neck, sometimes as many as six times in a day.

29. Prison staff said she did not lose consciousness completely when she tied ligatures, but the material was usually tied tightly enough to stop her breathing and the ligatures were often very difficult to remove. Sometimes when staff found her she was dark blue and convulsing. Her repeated acts of self-strangulation resulted in headaches and nose bleeds. Ms Walker most often self-harmed when she was locked in her cell at lunchtime or at night. She was always in the same position, sitting on the floor with her back to the cell door. There was no record that she ever tried to hang herself by attaching the material to anything.

30. Ms Walker continued to be managed under ACCT procedures throughout her time in Bronzefield with weekly case reviews. (The records of two of these reviews are missing). Ms Walker always attended the reviews, but rarely made any contribution to the discussion. A senior prisoner custody officer was Ms Walker's ACCT case manager until late August but was then unavoidably away from the prison until after Ms Walker's death. She had also been her case manager during a previous sentence. She told the investigator that Ms Walker was usually quiet during reviews and was not open about her feelings. She preferred to be out of her cell but did not like using the gym or going to education

classes, and was not keen about applying for most of the available prison jobs. She gave Ms Walker unpaid jobs in the prison reception to keep her occupied and to get her out of her cell and said Ms Walker was happiest in small groups of about three people.

31. Ms Walker had a supportive family but she did not want her case manager to discuss her self-harm with them or involve them in the ACCT process. At the first case review on 26 March, the case manager wrote on the ACCT caremap (a care plan to identify the main issues confronting a person in distress and the action needed to reduce their risk) that staff did not need to hold an ACCT case review to reassess her risk every time Ms Walker self-harmed unless her method of harming herself changed.

32. Staff checked Ms Walker frequently. The records indicate that from 10 August, she was observed 24 times in each 12 hour period and staff were required to record two conversations with her each day. The front cover for the period before this is missing, but the records indicate that the frequency of the checks was the same. There were brief periods when Ms Walker's observations were increased (for example when she tied several ligatures in quick succession), but she was never observed less than 24 times in every 12 hour period.

33. Several staff often took Ms Walker for walks in the prison grounds. They encouraged her to work and keep herself occupied and let her out of her cell as often as possible to reduce her opportunity to self-harm. She attended several short courses in the education department during April and May and between 20 May and 6 August, she worked as a laundry orderly. Ms Walker sometimes spoke to Listeners (prisoners trained by the Samaritans to offer confidential peer support). A number of staff said they had tried to dissuade Ms Walker from tying material round her neck and had warned that there was a risk that she would die.

34. Prisoner A said she had known Ms Walker for about three months and said she was a mother figure to her in prison. She said Ms Walker had a bubbly character and was very good at hiding her feelings. Ms Walker talked to her in depth about her problems and her past. She said most of the time their rooms were unlocked so it was easy for them to talk often. She said she and a group of other women checked Ms Walker frequently because of her habit of tying ligatures. She said Ms Walker liked to tie them when she had a bath and used to hide them in her bra. When she tied ligatures in her cell she used to sit on the floor behind her door, facing the window with her back to the door. Ms Walker told her that she liked the "buzz and the tingling sensation" of tying something tightly around her neck. She said she used to warn Ms Walker not to do it, because one day she would go too far.

35. Prisoner B, who shared a cell with Prisoner A, said Ms Walker's self-harm was unpredictable. She often appeared to be in a good mood and laughed a lot. She would promise not to tie anything round her neck but, as soon as she was locked in her cell, she would do so. She thought that Ms Walker often tied ligatures at time when she knew officers were going to check on her.

36. In prison, responsibility for Ms Walker's mental health care under the Care Programme Approach passed from her care coordinator in the community to a care coordinator in the prison's mental health in-reach team. Between 25

February and 18 March 2015, her previous period in Bronzefield, Ms Walker was allocated to the caseload of a mental health nurse. As she had left Bronzefield less than two weeks before, Ms Walker rejoined the nurse's caseload when she came back to prison on 24 March, without any further assessment.

37. The mental health nurse did not see Ms Walker until 5 May, on this sentence. She said she had tried before but Ms Walker had refused to speak to her but there was no record of this in Ms Walker's medical record, which she acknowledged there should have been. On 5 May, she noted that she planned to see Ms Walker weekly but saw her only five more times, on 18 May, 26 June, 21 July and 18 September. She said that she had tried to see Ms Walker every week, but Ms Walker usually refused to see her. Again this was not recorded in her medical record.

38. The mental health nurse attended only one of Ms Walker's ACCT case reviews, on 12 August. The case manager said she had repeatedly emailed the nurse to invite her to ACCT reviews, but got no response. The nurse said she had no recollection of receiving emails from her, and did not know who she was. She said that when she had been invited to Ms Walker's ACCT case reviews, she was usually given too little notice and could not rearrange her day in time to go. The prison was not able to retrieve the case manager's emails from this period to establish what had happened.

39. The mental health nurse said she had found it difficult to form a professional relationship with Ms Walker, who she said was often silent during their sessions. Ms Walker told her she self-harmed when she felt low, but would not elaborate further. The nurse said that she spoke to her manager about this, who said that Ms Walker was the same with other mental health staff. She said she had raised Ms Walker's case at one of the team's weekly multidisciplinary meetings, but they had decided that Ms Walker was not ready for talking therapy. There is no record of this in Ms Walker's medical record. (Ms Walker had had several sessions with a counsellor at Bronzefield in 2014 but had stopped going because she said they made no difference.) The manager of the mental health in-reach team said she did not remember the nurse asking for help with Ms Walker.

40. On 6 May, Ms Walker was sentenced to 18 months in prison, and was due to be released on 23 December 2015. When she got back from court, a senior custody officer and a reception officer held an ACCT case review. Ms Walker was not very talkative, shrugged and said she felt okay. She tied another ligature around her neck when she was in her cell that evening.

41. On 8 May, it appears that in order to try to manage Ms Walker's self-harming behaviour, staff decided to charge Ms Walker with a disciplinary offence if she continued to damage prison property (sheets and clothing) in order to make ligatures to tie around her neck. This decision is referred to in the ACCT record, in a later support plan and officers talked about it when we interviewed them, but we have not seen documentation of the original decision and who took it.

42. On 12 May, Ms Walker cut her arm with broken glass. At an ACCT review the next day with her case manager and an officer, she said she was fed up with the other women on Houseblock 2 checking up on her and the case manager offered her some time out of her cell on her own. Over the following days, Ms Walker

continued to tear her sheets into strips to tie around her neck. On 19 May, after she had tied a strip of sheet around her neck for the twelfth time since 8 May, staff reminded her that she would be charged with a disciplinary offence for damaging prison property.

43. At 2.00pm on 20 May, Ms Walker tied another strip of sheet around her neck and was charged with damaging prison property. Afterwards, she refused to go back to her cell and staff used physical restraint techniques to move her. Staff charged Ms Walker with a second disciplinary offence for disobeying a lawful order. The case manager held an ACCT case review with Ms Walker. No one else was present. Ms Walker said she had become angry when staff told her she would be placed on a disciplinary charge. She appeared calmer at the review, but later that evening she tied another ligature and cut her arms.

44. Ms Walker pleaded guilty at a disciplinary hearing the next day and acknowledged that she had been warned she would be charged with a disciplinary offence if she continued to damage prison bedding and clothing to self-harm. She was fined £6.79, the cost of replacing the sheet. She received a suspended punishment for the second charge for refusing to go back to her cell.

45. Also on 21 May, a consultant forensic psychiatrist reviewed Ms Walker's medication. She told him that her depixol injections no longer appeared to have any effect and her self-harming had increased as a result. He increased Ms Walker's dose of depixol from monthly injections of 60mg to 100mg.

46. On 24 May, Ms Walker spoke at length to an officer during a walk in the grounds. She asked if she could go to the gym and he arranged for her to join a session for prisoners from the prison's inpatient unit.

47. On 27 May, at an ACCT review with the case manager and an officer, Ms Walker reiterated her frustration about the plan to charge her with a disciplinary offence if she tore her sheets. Ms Walker cut her arms with broken glass on 1 and 2 June.

48. On 2 June, staff began an additional management plan because Ms Walker had started tying material around her neck in the bath, when male staff were on duty and could not go into the bathroom to help her. Under the plan Ms Walker was allowed to use the bath between 9.30 - 10.30am and 2.00 - 3.00pm. She had to tell staff when she was going to have a bath and was searched before she went in. If Ms Walker used the bath outside the allocated times she would lose privileges under the Incentives and Earned Privileges (IEP) Scheme. The plan noted that Ms Walker had been told that she would face disciplinary charges if she continued to damage prison property.

49. On 3 June, Ms Walker told the case manager that she was unhappy on Houseblock 2 and wanted to move to Houseblock 3. She said she felt other prisoners were taking advantage of her as the laundry orderly. Ms Walker cut herself with broken glass on 4 and 5 June. The record of the ACCT review for 10 June is missing.

50. Ms Walker tore her sheet to make ligatures on 12 and 13 June. On 13 June, she was placed on a disciplinary charge for blocking her sink with a cloth and flooding her cell. She received a second suspended punishment at a hearing on 15 June.

51. On 16 June, Ms Walker spoke to the safer custody manager for over an hour. She said she had recently felt an urge to set herself on fire. She said she self-harmed on impulse because she had been sexually abused as a teenager and now felt able to speak about this abuse. At an ACCT review the next day, with the case manager and an officer, she said she had asked to speak to a member of the mental health in-reach team about counselling. There is no record of this in the ACCT caremap or in Ms Walker's medical record.

52. On 24 June, the case manager held an ACCT case review. No other member of staff was present. Ms Walker was tearful and said her mood kept dropping. She said she kept thinking about setting herself on fire. She said she had no television or access to the prison shop, and therefore nothing to distract herself when she was locked in her cell. (We have not seen any documentary evidence of the decision to take Ms Walker's television or stop her access to the prison shop.) The case manager wrote on the ACCT that she would invite a member of the mental health in-reach team to the next review as a matter of urgency. We have not been able to establish whether the case manager invited anyone from the mental health in-reach team, but no one attended.

53. On 30 June, Ms Walker was given a warning under the IEP scheme for not going to work as a laundry orderly. She cut her neck with broken glass later the same day. The next day, 1 July, the case manager rescinded the IEP warning and noted that Ms Walker had resigned from her job because she was struggling to cope. She said she would help Ms Walker apply for another job. She recorded on the ACCT caremap that Ms Walker should no longer be placed on a disciplinary charge for damaging her sheets because this had led to a change in her method of self-harm.

54. Despite this note on the caremap, at 8.20pm on 3 July, Ms Walker was charged with a disciplinary offence after tearing a sheet and tying it around her neck. She said she had self-harmed in response to hearing some bad news about her brother. At 9.25pm, she was charged with a further offence when she damaged another sheet and tied it around her neck. At a disciplinary hearing the next day, Ms Walker was punished with a fine of £6.79 and loss of access to a television and to the prison shop for two weeks.

55. The prison chaplain visited Ms Walker on 6 July, and noted that her brother was now doing well and she was feeling better.

56. Ms Walker used her sheet as a ligature again on 7 July. A senior custody officer, who held an ACCT case review with an officer later that day, noted that she would not be charged with damaging prison property. Ms Walker was moved to a single cell on Houseblock 3 after the review, as she had been asking to move. All of the cells in Bronzefield are designed as safer cells with reduced ligature points. Staff did not consider that Ms Walker needed to be constantly observed or moved to an inpatient bed in healthcare.

57. Between 8 and 14 July, Ms Walker used clothing to make ligatures eight times. At 1.15pm on 16 July, she tore a sheet to tie a ligature and was charged with a disciplinary offence. She damaged part of the same sheet at 6.15pm and was charged with another offence. Ms Walker was fined £6.79 as punishment for

damaging her sheet. The second charge was dismissed, as it related to the same sheet.

58. On 22 July, Ms Walker self-harmed by tying material round her neck six times and on 23 July, five times. At an ACCT case review on 24 July with a case manager and an officer, Ms Walker said she had not felt good for the previous two days but was due to have her depixol injection. She self-harmed eleven times (nine by tying something round her neck and two by cutting herself with glass) between 26 July and 2 August, including six separate incidents on 28 July. On 2 August, she told a senior custody officer at an ACCT review that she did not think her medication was working as well as it used to and this was causing her to self-harm more. He did not record any actions on the caremap and no one reviewed her medication.

59. Between 5 and 12 August, Ms Walker self-harmed once by cutting herself with a broken coffee jar and ten times by tying material around her neck. On 12 August, the duty manager held an ACCT case review with the safer custody manager, the mental health nurse and an officer after Ms Walker had tied torn pieces of clothing around her neck twice that morning. She noted that Ms Walker did not usually harm herself in the morning. The nurse said that staff had asked her to attend the review because she had happened to be on the houseblock on another matter.

60. At the case review, Ms Walker said she was bored and the safer custody manager suggested she work with the safer custody team to design more relevant in-cell distraction packs to help other women who self-harmed. The mental health nurse said she would find out whether Ms Walker was suitable for the Nexus Programme at HMP Eastwood Park, for women with personality disorders. The safer custody manager encouraged Ms Walker to apply for a job as a prison painter and noted that Ms Walker's personal hygiene was not at her usual standard. The case manager planned the next review for 17 August and made a note to invite the nurse. The record of ACCT review scheduled for 17 August is missing.

61. Ms Walker did not harm herself at all between 17 and 24 August. On 25 August, she refused to leave another prisoner's cell and staff forcibly took her back to her cell. She tied five ligatures that day, including three between 10.00am and 10.30am. She received a suspended punishment at a hearing the next day for refusing to go back to her cell.

62. At 6.45pm on 28 August, Ms Walker was charged with another disciplinary offence after tying part of a prison t-shirt around her neck. She was fined £6.79 at a disciplinary hearing on 30 August.

63. On 1 September, Ms Walker told a member of the Independent Monitoring Board that she had been sexually abused as a child, and that she had abused someone else. She would not give any further details. The same day, Ms Walker used broken glass to make cuts on her throat. There is no entry in her medical record about this. Between 2 and 12 September, Ms Walker tied material, mostly torn clothing, around her neck 12 times. At 8.00pm on 2 September, she was charged with a disciplinary offence for damaging her duvet to make a ligature. On 4 September, she was fined £2.99 as punishment.

64. On 13 September, Ms Walker was demoted to the basic regime under the IEP scheme, after she pushed an officer in the exercise yard. The prison could not find the IEP records relating to this incident. That day, she tied ligatures around her neck five times and flooded her cell. She was charged with a disciplinary offence for flooding the cell and received a suspended punishment. She was not charged with damaging prison property by making the ligatures.

65. On 14 September, Ms Walker started working in the gardens with an officer. The officer said she knew Ms Walker from her previous times at Bronzefield and had a very good relationship with her. She thought Ms Walker had really enjoyed working in the gardens. She said Ms Walker was quiet but the other women working in the gardens had taken her under their wing.

66. On 16 September, at an ACCT case review with a case manager and an officer, Ms Walker said she was enjoying her new job. She said she regretted pushing the officer and tying ligatures on 13 September. She said she had tied a further three ligatures during the night because she had heard other prisoners talking about her and it had got on top of her. Ms Walker did not say that she was being bullied and the case manager did not consider that any further action was necessary.

67. On Friday 18 September, Ms Walker told an officer that she was being bullied by two women on the houseblock and felt alienated. She asked Ms Walker if she wanted her to talk to these women, but Ms Walker thought this might make things worse and said she would prefer to move to another houseblock. She advised her to speak to Houseblock 3 officers about this.

68. On 20 September, Ms Walker was put back on standard level of the IEP scheme. On Monday 21 September, work in the gardens was cancelled because it was raining and an officer asked Ms Walker to help her sort out the gardening uniforms. She said they spoke for an hour and Ms Walker told her that she had been sexually abused as a child and this was at the root of her self-harm. Ms Walker said that she had then sexually abused other children. The officer did not think that the incident Ms Walker described sounded like sexual abuse. Ms Walker told her that she had confided in another prisoner about this but they were no longer friends.

69. On 22 September, the officer saw Ms Walker again, and thought she seemed in good spirits. On 23 September, Ms Walker told the officer again that other prisoners were bullying her and she wanted to move. The officer spoke to Ms a Houseblock 3 manager, but the manager did not agree that Ms Walker should move. The officer said Ms Walker cried when she told her this. The officer was not on duty for the rest of that week.

70. The Houseblock 3 manager said she had known Ms Walker for a number of years. She said Ms Walker was popular with other prisoners, who kept an eye out for her and told the officers if they were concerned she was harming herself. She said that the officer had told her Ms Walker wanted to move to a different spur because other prisoners were upset with her. She said that she did not think that Ms Walker was being bullied, but that she had fallen out with them and believed they needed to resolve their problems rather than run away from them.

She said she had asked the officer to encourage Ms Walker to try to resolve the problem with her friends before they considered moving her.

71. Also on 23 September, a senior custody officer and an officer held an ACCT case review. The officer said she did not stay in the review long because Ms Walker asked to speak to the senior custody officer alone. The senior custody officer said Ms Walker appeared her usual self and asked him if the Houseblock 3 manager had spoken to him about moving her to a different spur. He said she had not. After the review, he discussed the ACCT document with his manager and said he had found the caremap disorganised. He was concerned that, as Ms Walker was a prolific self-harmer, they were not using the enhanced case review system to manage her care. No action was taken about this before Ms Walker's death.

72. Prisoner A said that, some weeks before she died, Ms Walker had told her that she had been sexually abused when she was a child and that she had sexually abused two young members of her family. Ms Walker told her that she could not live with the guilt and hoped she would not feel differently about her. She said she had tried to reassure Ms Walker that she would not.

73. Prisoner B said Ms Walker had also confided in her. She said Ms Walker appeared to feel increasingly guilty about events in her childhood. She said that Ms Walker started to think that other prisoners were talking about her, but they were not.

74. On 24 September, Ms Walker tied three different strips of sheet around her neck in an hour.

Friday 25 September 2015

75. Prisoner A said Ms Walker came to see her in her cell for a chat on the morning of 25 September, after they were unlocked. She said she felt that no one on the wing was talking to her. The prisoner told her that she felt depressed and had not been ignoring her. That afternoon, Ms Walker seemed her normal self. Prisoner B said she checked on Ms Walker at about 5.00pm, when they were being locked in their cells and she seemed fine.

76. Prisoner C, who lived in the cell directly above Ms Walker, said she knew Ms Walker well and did not think that she was her usual happy self that week. She said she knew Ms Walker had talked to Prisoner A during the day, but did not know what they had spoken about. She also talked to Ms Walker during the day and they had shared a joke in the laundry. She thought Ms Walker was in better spirits and had talked about what she would do when she left prison at the end of her sentence. After they were locked in their cells, she shouted good night to Ms Walker and she responded normally.

77. The prison telephone system records show that Ms Walker telephoned her family at 4.44pm on 25 September and spoke to them for 35 minutes. The investigator listened to a recording of the call. Ms Walker spoke to her mother, nephew and aunt and gave no apparent indication that she was thinking of harming herself. The ACCT record shows that Ms Walker was locked in her cell for the night at 5.12pm.

78. Officer A, who was on duty on Houseblock 3 that evening, said that, at about 5.45pm, a prisoner complained of chest pains and shortness of breath. She telephoned for a nurse and also told the Houseblock 3 manager, who was in charge of the operation of the prison at the time. The manager asked Officer B to go to Houseblock 3 so that Officer A could open the prisoner's cell for the nurse. (At Bronzefield, two officers should be present when a cell is opened in patrol state when prisoners are locked in their cells and there are fewer staff on duty.)

79. Before Officer B arrived, Officer A asked two other officers, who had arrived to deliver some papers, to watch the prisoner who was ill while she checked Ms Walker again. CCTV shows that Officer A looked through Ms Walker's observation panel at 5.55pm. She saw that Ms Walker was face down on the floor, shouted for help, radioed a medical emergency code blue and unlocked the cell door within 30 seconds. Officer B followed Officer A into the cell and together they removed a very tight ligature made from a strip of sheet from Ms Walker's neck.

80. The Houseblock 3 manager said that when she heard the emergency code, she assumed it related to the prisoner Officer A had told her about, a few minutes earlier. She picked up an escort pack, in case the prisoner needed to go to hospital, and ran the short distance to Houseblock 3. When she arrived, three officers were putting Ms Walker into the recovery position. She immediately decided Ms Walker needed cardiopulmonary resuscitation and asked them to put Ms Walker on her back. She checked Ms Walker's airways and began chest compressions. Before she had completed 30 compressions, two nurses arrived with oxygen and a defibrillator.

81. CCTV showed that the nurses arrived at 5.56pm. One nurse said she had arrived on Houseblock 3 to examine the other prisoner when she heard the code blue. She went straight to Ms Walker's cell and arrived as she was being laid on the floor. She gave Ms Walker oxygen and her colleague attached the defibrillator. The defibrillator found no shockable heart rhythm and the nurses and officers continued cardiopulmonary resuscitation.

82. An officer on duty in the control room called an ambulance as soon as he heard the code blue. CCTV showed that the first paramedics reached Ms Walker's cell at 6.09pm and a second crew arrived shortly after. The paramedics found a faint pulse but Ms Walker was not breathing on her own. At 6.50pm, paramedics took her by ambulance to hospital.

Contact with Ms Walker's family

83. An officer and a prison chaplain acted as family liaison officers. At 8.25pm, the officer telephoned Ms Walker's mother to tell her that Ms Walker had been taken to hospital and was in a critical condition. Ms Walker's mother and aunt travelled to the hospital that night and they and other members of her family were with her when she died on 27 September. The prison paid funeral costs, in line with national policy.

Support for prisoners and staff

84. After Ms Walker was taken to hospital, the senior manager in charge of safer custody debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and offered her support. The staff care team also offered support.

85. Two managers went to see all the women on Houseblock 3 to tell them what had happened and offer support. Listeners also spoke to them. After Ms Walker's death, the prison posted notices informing other prisoners and offering support. Staff reviewed all prisoners assessed as at risk of suicide and self-harm, in case they had been adversely affected by Ms Walker's death.

Post-mortem report

86. A post-mortem examination concluded that Ms Walker died as a result of hypoxic brain injury, cardio-respiratory collapse and ligature compression of the neck. Toxicological tests detected no drugs in Ms Walker's body.

Findings

Managing Ms Walker's risk

87. The investigation found that much of the care offered to Ms Walker by individual staff was good. The required daily conversations were recorded in ACCT documents in appropriate detail with some meaningful comments. Officers' entries in the ACCT documents showed some good rapport with Ms Walker. Ms Walker was not always keen to work or engage in activities in the prison, but during the periods when Ms Walker was not formally employed, her case manager tried to keep her occupied her with small unpaid jobs in the prison reception. Several staff took Ms Walker for walks in the prison grounds to keep her occupied and because she enjoyed being outside. For the same reason, staff allowed her out of her cell more frequently during the day than would usually be allowed. An officer made good efforts to ensure that Ms Walker got a job in the gardens – a trusted job that she appeared to enjoy very much.

88. Staff were caring towards Ms Walker and genuinely wanted to help her. However, Ms Walker was a very challenging person to manage and support. She was a prolific self-harmer and was unable to articulate properly the reasons for her behaviour. She was unwilling to engage in talking therapy and disliked being in large groups.

89. We are satisfied that staff recognised her high risk of self-harm and set an appropriate level of observations. Constant supervision would not have been appropriate as this should be used only at times of acute crisis and for the shortest time possible, usually in response to a credible wish to die. Long term use of constant supervision can be detrimental to someone's welfare.

90. Staff and other prisoners warned Ms Walker many times that her chosen method of self-harm was extremely dangerous, but she was apparently unable to stop. Ms Walker rarely spoke about whether she intended to kill herself and this did not usually appear to be her intention. No one we spoke to thought she wanted to die. Ms Walker had a long telephone conversation with her family before she was locked in her cell on 25 September. She appeared happy and talkative and spoke about the future. It does not appear that the act of self-harm on 25 September that led to Ms Walker's death was any different from the numerous previous occasions when she had tied something tightly around her neck. There is no evidence that Ms Walker intended to kill herself on 25 September and it seems that her death was the consequence of her very risky self-harming behaviour.

91. We consider that, given the nature and frequency of Ms Walker's self-harm, it would have been extremely difficult for prison staff to have prevented her death. However, the investigation identified some deficiencies and room for improvement in ACCT procedures, designed to support prisoners at risk of suicide and self-harm, which we set out below.

ACCT procedures

92. Prison Service Instruction (PSI) 64/2011, which gives guidance on how to manage suicide and self-harm procedures, requires ACCT case reviews to be

multidisciplinary where possible, involving staff from relevant departments and services. Ms Walker had 28 case reviews between March and September 2015. Only one of these had a member of healthcare staff present, despite her prolific self-harm and acknowledged mental health problems. None of the other reviews was multidisciplinary and several reviews had just one member of staff present, which is poor practice. Even when multidisciplinary attendance is not possible, it is implicit that ACCT case reviews, which are based on teamwork, involve more than one member of staff. The PSI notes that the process operates more effectively when there is continuity in attendance. Few of the same staff attended Ms Walker's reviews.

93. The case manager said she had repeatedly invited the mental health nurse to ACCT reviews but the nurse denied knowing who the case manager was, said she had not been regularly invited and that when she was, she was given too little notice to attend. We have been unable to verify this account, but we would have expected more consistent input from the mental health team, especially as the nurse was Ms Walker's care coordinator. During previous sentences, Ms Walker's care coordinator in the prison and the Head of the mental health in-reach team often attended her ACCT case reviews.

94. Continuity of ACCT case managers is important to provide consistency of approach and to ensure identified issues are addressed and resolved over time. The case manager provided good continuity of care until she was away from the prison in late August for a period. After that, there was no consistent case management.

95. PSI 64/2011 requires caremaps to reflect the prisoner's needs, level of risk and the triggers of their distress. Caremaps should aim to address issues identified in the ACCT assessment interview and later reviews, and consider a range of factors including health interventions, peer support, family contact and access to diversionary activities. Each action on the caremap must be tailored to meet the individual needs of the prisoner, be aimed at reducing risk and be time bound.

96. Ms Walker's caremap contained numerous entries but they were confusing and hard to follow. It was not clear which actions had been achieved and which were outstanding. Not all of the decisions taken at reviews were properly reflected in the caremap, particularly those about meeting Ms Walker's mental health needs.

97. Some of the care planning lacked coherence and consistency. On or around 8 May, someone (we have not been able to establish who) decided that Ms Walker should be charged with damaging prison property when she tore prison bedding and clothes to make ligatures. Ms Walker was first charged with damaging property on 20 May and fined. On 30 June, the case manager decided to abandon the plan because it seemed to have had the perverse consequence of Ms Walker changing her method of self-harm to cutting, rather than reducing her propensity to harm herself. Despite this decision, staff charged Ms Walker with damaging prison property on 3 July, 16 July, 28 August and 2 September. Each time she received a fine, and on 4 July she also lost access to the prison shop and her in-cell television for two weeks.

98. PSI 47/2011, which covers disciplinary procedures in prisons, requires adjudicators to take account of the likely impact on the prisoner, including their

health and welfare. It does not appear that this was taken into account when Ms Walker lost her television, which allowed her some distraction. Nor is there any record that further decisions such as reducing her to a basic regime took into account her welfare. The PSI says it would not normally be appropriate to lay disciplinary charges where the prisoner's actions were related to self-harm or preparation for it. We understand that charging Ms Walker for tearing sheets and clothing was a deliberate strategy to try to reduce her self-harming behaviour but it was not part of a coherent plan and was not applied consistently.

99. PSI 64/2011 recommends that prisoners at risk of suicide and self-harm are managed under an enhanced case review process in a number of circumstances, including when they are prolific self-harmers like Ms Walker. Management by an enhanced review team is not mandatory, but it includes more specialists and a higher level of operational management. With the complexity of Ms Walker's behaviour, it would have been appropriate to consider an enhanced case review approach. A more high-level approach from an enhanced case review team might have resulted in more regular attendance by mental health staff at reviews and a more coherent approach to managing Ms Walker's behaviour.

100. The prison has acknowledged the lack of consistency in case management and multidisciplinary involvement, specifically from the mental health team, in Ms Walker's care. Since Ms Walker's death the mental health in-reach team have undertaken training on self-harm, ACCT refresher training and greater efforts have been made to ensure that they attend ACCT reviews. Bronzefield has also introduced a new system of case management so that another designated member of staff takes over if the case manager is absent for a long period. We welcome these developments and make the following recommendation.

The Director and Head of Healthcare should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including:

- **Holding multi-disciplinary ACCT reviews with continuity of case management and involving all staff who can contribute to the care of a prisoner at risk.**
- **Using the enhanced case review process when appropriate.**
- **Setting effective caremap objectives which reflect decisions from reviews, are specific and meaningful, and which identify who is responsible for completing them and when they have been completed.**

Management of Ms Walker's mental health

101. The clinical reviewer concluded that, over her several periods of imprisonment, Bronzefield provided a good level of mental health support for Ms Walker. Records show that considerable efforts were made to engage her in therapy and find a way of helping her to reduce her self-harming behaviour. However, we are concerned that this level of effort and engagement was not sustained during her final sentence. We are pleased that the mental health team appear to have taken some measures to improve multidisciplinary working in the ACCT process. However, we are concerned that the mental health nurse, Ms Walker's care

coordinator, appeared to have little involvement with her during her last sentence and said that Ms Walker often refused to engage with her. We accept that Ms Walker might have been reluctant to engage but this was not recorded in her medical records at the time and her mental health care plan was not always kept up to date. We make the following recommendation:

The Head of Healthcare should ensure that prisoners subject to the Care Programme Approach have a documented therapeutic plan with clear objectives and that their care coordinator in the prison meets them regularly to update the plan and records all contact and concerns.

Ms Walker's request to move houseblock

102. An officer said that Ms Walker had asked to move to a different houseblock in the week before her fatal act of self-harm. Ms Walker told her that she was no longer friends with some women she had confided in and said that she felt bullied. Three prisoners who were known to have been friends with Ms Walker acknowledged that she had confided in them, but said that they had not fallen out with her. A Houseblock 3 manager decided not to move Ms Walker but instead wanted to encourage her to resolve her differences with other prisoners. The manager did not think Ms Walker was being bullied. It seems that Ms Walker was sensitive about how her friends might respond to her after she had divulged information about her past to them, but they deny reacting adversely. We consider that the manager's approach was reasonable and there was no overriding evidence to support a move.

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