HOUSES OF PARLIAMENT

Joint Committee on Human Rights

Uncorrected oral evidence: Mental Health and Deaths in Prison, HC 893

Wednesday 8 March 2017

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Watch the meeting

Members present: Ms Harriet Harman (Chair); Ms Karen Buck; Baroness Hamwee; Jeremy Lefroy; Baroness O'Cathain; Amanda Solloway; Lord Trimble; Lord Woolf.

Questions 57 - 75

Witnesses

I: Ms Donna Saunders; Mr Mark Saunders; Ms Clare Hobday Saunders; Ms Deborah Coles, Director, INQUEST.

II: Ms Sheila Waplington; Ms Marlene Danter; Ms Deborah Coles, Director, INQUEST; Selen Cavcav, Caseworker, INQUEST.

Examination of witnesses

Ms Donna Saunders, Mr Mark Saunders, Ms Clare Hobday Saunders and Ms Deborah Coles.

Q57 **Chair:** Thank you very much to the Saunders family and to Deborah Coles for coming to give your evidence and to tell your story to this very important inquiry. We are the Joint Committee on Human Rights and we are half Members of the House of Lords, half Members of the House of Commons—MPs—and we are cross-party. We hear evidence on an important issue and make a recommendation in our report that goes to the Government.

The first thing that we all want to say to you is how tremendously sad we are for your loss and for the absolute tragedy that you have suffered and

the grief that is still with you—all the more so because, as you said so strongly yourself, not only was Dean's death as such a very young age predictable, but you had actually predicted it. There can hardly be anything more important to look into than the question of suicides in prison, which is what we are inquiring into at the moment.

This is a very important time for you to give us your evidence, because we have a Bill that the Government have produced, called the Prisons and Courts Bill. The question of law in relation to prisoners, prison officers and the prison department is right at the top of the agenda right now. We are all very grateful for your preparedness to speak publicly—you are speaking to us in this Committee room, but you are actually speaking to the whole of the House of Commons and House of Lords and to the Government—and for your evidence.

This is obviously a very difficult question for you to answer, but can you in your own words explain what happened to Dean? What were the key opportunities that were missed to save Dean's life? Do not worry if you repeat each other, and if you leave anything out you can always come back to it.

Clare Hobday Saunders: Dean felt unwell extremely quickly. It started on 18 December 2015. There was an altercation. He locked himself in a bathroom, in a very paranoid state. He was convinced that people were after him and that his life had a severe threat to it. He was then taken under Section 136 to Rochford hospital, which is an assessment unit where they look at the treatment that they are going to provide to the individual.

It was decided when he was there that, yes, Dean was very unwell. He was paranoid, but he did not seem an immediate threat to others or to himself directly, he just seemed very scared and stressed and needed support. They decided that he would go back to Donna's and Mark's—his parents'—house and that a crisis resolution team would come out the next day to discuss treatment plans, whether it be medication, et cetera.

On that night when he went back to Donna's and Mark's, he seemed okay, although very unsettled. But then he got progressively worse and there was an altercation when he went into the kitchen and picked up a knife and went towards his brother, saying that his brother had changed. Mark went into the kitchen and tackled him. There was a scuffle in which Mark tried to get the knife off Dean, because Dean said that he knew what he had to do; he knew he had to take his own life before other people could. Mark got injured and Dean tried to slit his throat, but he could not do it because the blade of the knife was the wrong way round. In that moment, Mark was able to stop him from taking his life there.

While this was going on, a phone call was made to the police to get them to come along to help both Dean and Mark, who had been injured in the altercation. Dean was then taken to Basildon police station. We explained

to them what had happened, that he had been in hospital the day before and that he was under the crisis resolution team and was known to be unwell. The police were completely under the impression that he was just going to be sectioned; it had been set up that he would speak to the nurses and then to psychiatrists the following day. After about 72 hours he had an assessment with the psychiatrists and, as he would not co-operate and would not talk, they decided that it was not suitable for him to be sectioned.

Mark Saunders: One of the psychiatrists at that assessment had sat in on the assessment the day before, when they were borderline about whether or not to keep him in. They asked for a voluntary entry but Dean, obviously in his paranoid state of mind, would not do that. That is why it was agreed that he would come back to us. The psychiatrist who saw him the day before knew the situation and the background and knew that Dean was borderline—and that he had got worse through the night. Then they came out from that assessment in the police station saying that it was inconclusive because he was not co-operating.

I was told this in a phone call and I said, "How could you say that?", because my son stood in front of me with a knife against his neck and said, "Dad, the only way I can beat them is to do it myself". How can they say there are no underlying mental issues? I asked them if it was because there was nowhere to put him. I kept phoning up to chase this assessment and one officer said that he had known them to take a while, because normally they would be trying to source a place, so that once he was assessed he could then get moved. I asked if there were no beds and if that was why. They said no, that was not the reason; the reason was that they were there to do a one-to-one interview and did not take anything else into consideration.

These are the professionals telling you that and you take it at face value. Obviously now, later down the line, we find that that was not true. It seems that they did source beds, but only locally. Once it got to that stage, they should have tried out-of-area beds, even in the private sector if there were no out-of-area beds. In the information that was brought forward, it went only to local beds and then it seemed to stop.

Chair: Mark, is that the first moment at which you think a wrong turn was made?

Mark Saunders: The failings began then.

Chair: The opportunity was missed. Was that a key moment when he was not diverted to where he needed to be?

Mark Saunders: Yes, definitely.

Donna Saunders: You asked for a second opinion, Mark.

Mark Saunders: Yes, I did. I said that I did not think it was right and that surely it was in our right to have a second opinion. They said that time was running out and, because he was in custody, they had to make a decision. They said that the clock was ticking and, if they had to do another assessment, the outcome would be the same because he was not willing to take part. They decided that he would have to go through the justice system.

Donna Saunders: To backtrack, when he was at Rochford under Section 136, I stayed with him overnight. He was that paranoid that he would not eat or drink unless I tasted it to make sure that it was okay, because he thought that they were trying to drug him.

When they asked if he would go in voluntarily, he said that he would, but only if I could stay with him, because that would make him feel safer. They said that they could not facilitate that, so that is why it was thought best that he come home, so that he was in an environment with people who he knew and trusted, rather than going in voluntarily and then walking out because he felt unsafe. At that point, they did not feel that he needed to be sectioned. They felt that it should be voluntary.

The following day, after things had escalated, the lady who went to see him in the police station—this is the bit that I do not understand—was the one from Rochford who had initially said to me that he was showing signs of paranoid psychosis. She said that on the day at Rochford, and on the following day when he had got worse and tried to kill himself it was, "Inconclusive, because he won't talk to us".

Q58 **Chair:** So you feel that it was something to do with what provision and services were available.

Donna Saunders: There was definitely something else going on.

Chair: I should just say that Amanda, who is one of our MPs on the Committee and who instigated this inquiry because of her concern about these issues, has had to pop out for some other parliamentary business. She will be back shortly.

Donna Saunders: I felt very let down at that point. She basically changed her opinion overnight from, "Yes, he's really not well", to, "It's inconclusive and he'll have to go through the court".

Chair: And moving on?

Mark Saunders: The options given to us were that he had to go through the justice system. We said, "Where do we go? We don't know. We've got to take information from you". Obviously they could not release him, because at that point he had crossed the line. He told police officers there that, if he had the opportunity, he would take his own life. Dean had looked into this alternative reality, which was real to him: there were these outside forces who would give him a slow, torturous death and his

only escape would be to take his own life and finish it that way. We asked, "So he's got to go into the justice system, but what will be the next steps?" They said, "He'll go to court". Because of my injuries and the attack on his brother, they could hold him on attempted murder. They did not expect that charge to stand by the time it got to court, but that would put him into remand. They said, "He can go into remand at Chelmsford, go straight into the medical wing"—

Donna Saunders: "Prison hospital" was the phrase they used.

Mark Saunders: Yes. They said, "He can go into the prison hospital, where he can get further assessments and start being looked after. We'll do all these other assessments, earmark him for emergency transfer and then put him where he needs to be. We can sort the charges out later on down the line".

Donna Saunders: They said that in the meantime this was a place of safety.

Mark Saunders: They said that it was a place of safety. We were told that it was a hospital wing. We did not know any different. We thought that we were out of options, so that is what happened—that is the way it went. But we said, "You've got to make sure that when he goes into the prison, they know that he's suicidal and will take his own life when given the opportunity". They said, "We'll send the bells and whistles and everything over with him so that they fully understand". They did. He entered Chelmsford and everything was put into place. It seems that, the first weekend he was there, he was under constant watch and everything was running how it should. It is almost as if, on Monday morning, on the handover, there was a discussion and a decision; there was meant to be a clinical review of his ACCT to see if he should continue with the constant watch, but no one who had mental health training or medical training attended that review. We found out from the inquest that it was predetermined that he was going to come off due to budgets and cost. It was decided on that Monday morning on the handover that he would come off.

Chair: Was your understanding that the budget and cost issue was about staff ratios?

Donna Saunders: I do not believe that lack of staffing had anything to do with Dean's case, because he was in the medical wing. There were only 12 inmates. There were sufficient staff on that unit.

Mark Saunders: When someone goes on to constant watch, instead of using permanent staff to take them from the floor to put them on a one to one for a constant, they bring in an agency. Obviously that agency costs money and that comes out of the budget. The head of healthcare was heard to say, "These constants are costing my budget".

Chair: So you think the decision to drop him down from constant surveillance to just twice an hour was to do with the cost and that that was the decision that was made at that point.

Mark Saunders: The inquest pretty much showed that.

Clare Hobday Saunders: Basically, the ACCT review is multidisciplinary. It is meant to have medical staff, preferably mental health-trained staff—obviously, the people who are on an ACCT review have mental health issues. There is also meant to be a prison officer and obviously the inmate themselves. Families can be involved; that can happen, but they do not seem to facilitate it that much. There was a conversation prior to his ACCT review that took him from constant observation to every 30 minutes. But they knew that the decision would be to take him off constant observation before they even walked into the room.

Q59 **Chair:** Do you think that if you had been there at that review as the family, that might have—

Donna Saunders: I begged them not to take him off. I told them that he would do it if they did not put him back on constant watch. They did not invite me to that meeting.

Chair: You were not at that review.

Donna Saunders: No, I was not at the review, but I had gone for a visit and I had asked to speak to somebody. Clare and I had gone into a side room and had a chat with—what was her title? She said that she was head of healthcare, but she was not.

Clare Hobday Saunders: She was team leader.

Donna Saunders: Team leader. There was somebody else in there as well. I told them all that, on the visit, Dean told me that there was a room in the prison that he had seen—it was a clinic—that had a chair and gas cylinders in it. He said, "That's where they're going to take me and do a live autopsy on me". That is what he thought they were going to do. I told them this. I had no way of knowing that that room was there, because I had never been through that side of the prison. I had only been to the hall. They just said, "Oh yes. That's our clinic. Don't worry. We'll put him straight on that". I begged them to put him back on. They did not invite me into the ACCT review. They sent me home. Within 15 or 20 minutes of leaving the prison, we had a phone call saying, "No, we're not putting him back on constant watch. We feel that half hourly is sufficient". I actually said to them on the phone, "Is this being recorded, because I'm telling you now if you don't put him back on he will kill himself? You won't be able to say that you didn't know or you were unaware. It will be your fault". Still they did not listen.

Mark Saunders: Initially when they took him off the constant watch on that Monday morning, we were not informed. We were not informed that he had come off until that visit and Donna raised concerns.

Clare Hobday Saunders: It was dropped very casually to us.

Mark Saunders: It was just dropped into the conversation: "He's now on half hourly". We were never informed. As Donna said, one of the answers to her many concerns was, "We'll have another ACCT review", yet these two are standing there, so why were they not invited to go to this ACCT review? Another thing was that on that Monday morning, just half an hour before that non-clinical review—it should have been a clinical review—he placed a plastic bag over his head and tried to suffocate himself and kill himself. This was noted in the ongoing report for Dean.

Clare Hobday Saunders: And the night before that review, he had threatened to pour boiling water over his head. Two self-harm acts took place, yet they still did not take any of that into consideration on that Monday morning for that review.

Mark Saunders: That is it. The markers were there, the flags were there. At the inquest, we heard that they sat there with the report in their hands. We questioned whether the individuals there knew their parts and roles in these ACCTs. One prison officer said he felt like he was just a bit of muscle and felt like an ornament in these ACCT reviews. No one seemed to know their goals or the roles they should play. That was the main thing: this one individual, who was in charge of the healthcare budget, took it upon herself to make the decision to take him off.

Donna Saunders: Some of the people sitting in on these reviews had not met Dean and did not know him, and had not bothered to read his notes. How can you do a review on someone if you have no information on them?

Clare Hobday Saunders: Dean was never allocated a personal officer or a caseworker. There were seven or eight ACCT reviews over the time he was in there, but there was never any consistency between the people who were taking part in them. As I see it, the main reason why they had the prison officers as well as the medical staff was that Dean was obviously going to have a different relationship with the medical staff from the one he would have with the prison officers. He might get on with the prison officers, or he might look at the nurses' uniforms and not take a liking to them. That is why they have multidisciplinary staff: so they can get the greatest amount of information of individuals.

Donna Saunders: Also, they did not pick up on the next ACCT review after the one where he had been taken off. No one seemed to pick up on the fact that it was two unqualified people who had taken him off.

Mark Saunders: On each ACCT review they just seemed to come in and do that one review without referring to the others. It felt like they were saying, "Since the other one it's been okay, so we'll do this one". No one looked back and said, "Hold on, that decision should never have been made in the first place". There was a kind of knock-on effect where they came in, saw Dean at that moment and did the ACCT review at that moment. They never seemed to look at the information that was held.

System 1 was introduced because of a recommendation from the PPO at a previous inquest about gathering information. That was in place but they were not using it, so some of these recommendations have been implemented but they are not practised. Staff were not fully aware what they should do and who had access. This comes back to what you were saying about the overall caseworker sitting on each ACCT review: no one knew what the role of the caseworker was. They just thought, "Isn't it the person who chairs the meeting at the time?" They were totally unaware.

Deborah Coles: Can I add something here? It is very obvious from what the family has said that all the warning signs were there. As you said at the beginning, it was predictable and indeed predicted. At every stage, everyone who was involved with Dean knew he was at serious risk. You asked about missed opportunities and I thought it would be helpful to pick up some of what the family have said about where they could have been a meaningful intervention. There is no forensic psychiatric assessment, and that was quite significant. He had two assessments but they were not forensic assessments, and the jury found significantly at the inquest that the mental health assessment that was done at the police station was inadequate. There was a consequent failure to pass on relevant information.

Then there are questions to be asked about why he was to be charged with attempted murder, given that the seriousness of the offence was attempting to prevent Dean from harming himself. That raises questions about whether at court in the remand hearing the judge could and should have ordered a forensic psychiatric assessment. We are supposed to have much better liaison and diversion services now, because it is well recognised, and you have heard evidence about this already, that prisons cannot be places of safety. Once Dean was in the system, this family—and we have come across this time and time again—put the prison on notice frequently about the risks that he posed.

I am particularly concerned about the fact that the ACCT process was designed to protect prisoners at risk of suicide and self-harm. This is someone who was known to be at risk. There is provision in there to involve families in those ACCT reviews, and time and time again we have seen that that just does not happen in reality. The failings that were identified at the inquest about the way in which the ACCT process was running at Chelmsford are even more disgraceful when one considers that between 2010 and the time when Dean died there had been 11 previous

self-inflicted deaths that had also raised concerns about the management of ACCT. The frustration, sadness and indeed anger about these cases comes from the fact that, sadly, Dean's death was not the first and will not be the last.

Chair: You are coming back to us next week, Deborah, which will be a really good opportunity for you to bring the wider lessons. Can we go to Sally now, who will ask another question of the families so that we can hear your direct experience?

Q60 **Baroness Hamwee:** Thank you for explaining all that. I feel almost foolish asking these questions, but we want to get it on record from you. You have talked about the ACCT reviews, of which there were seven or eight. Over what period was this?

Clare Hobday Saunders: Over the two and a half weeks that he was in Chelmsford Prison.

Baroness Hamwee: So about every other day?

Clare Hobday Saunders: Yes. He was put on an ACCT review on the Friday, and the review that took him down to half-hourly observation was on the Monday. Then I believe they were every other day until he had his last ACCT review on 31 December. There was then a five-day gap where there was no review, and then Dean passed away on 4 January.

Baroness Hamwee: I wanted to ask how the prison authorities should have involved you. Did they tell you when the reviews were about to happen?

Donna Saunders: They told us nothing at all. Clare and I between us were phoning up pretty much every day because we were concerned about him. I asked whether he was eating and was told yes. I asked "How is he?", and they told me, "He's fine, he's safe, he's secure. There's nothing in his room he can hurt himself with. Don't worry. He's secure until we can get him transferred". They could not even keep him safe for two and a half weeks when they knew they would be looking after him for a short period.

Clare Hobday Saunders: It was only when we received the paperwork regarding Dean's case through the inquest that we discovered all these self-harm attempts. We were being told that he was safe and secure and nothing was wrong, so to us he was doing okay. It was only after that we found out that he had two and a half weeks of suffering where he was progressively getting worse and still getting no help, and was getting no intervention from us or from authorities.

Donna Saunders: And no contact with us. He had been asking for phone calls. They did not facilitate any. We were asking them to pass messages on to him. I spoke to them daily. Why could they not take down a telephone number?

Baroness Hamwee: Yes, we have some information about that. So the contact that you had with the prison was all instigated by you?

Donna Saunders: Yes, exactly. Even after he died, they did not let us know where his body was. We had already found him and were with him by the time they got round to phoning us and saying, "He's in this morgue".

Mark Saunders: When they phoned us up, that would have left us with about a half-hour window to get to the mortuary.

Donna Saunders: Which we would not have made because we would have had to come from Basildon.

Mark Saunders: Fortunately we were already there, but that was only through our own efforts to find where he was. Like I said, by the time we heard from them, if we had still been at home we would not have seen him that day.

Q61 **Baroness Hamwee:** Is there anything more that you can suggest about how they could or should have involved you in what was going on?

Donna Saunders: They knew that we cared. I am sure there are some people in prison whose families are not that close and who do not want them involved, but Dean was asking to contact us and we were asking to contact Dean. All they had to ask was, "Can you come to the review?", and we would have been there. We did not know that we had that right. If you have not dealt with mental health in prisons, you do not know any of the protocol. Even when we went for the visit, we did not have a clue. We went to the wrong place and had to be sent somewhere else. We had to be talked through it step by step, because we did not know—we had never been. The presumption is that you do know and that you have been.

Mark Saunders: With regard to contact with Dean, we just presumed that Dean had not contacted us because of his paranoia around phones. It was not until afterwards that we found out that he had wanted a phone call the Sunday before he died.

Clare Hobday Saunders: On the Sunday before he died they finally asked me for my telephone number. Dean died on Monday the 4th. On Sunday the 3rd I called up—like Donna said, we had been calling every day just to see how he was—and his team leader said, "Dean has been asking to have a phone call with you and to write a letter. Can I have your telephone number?" I was a bit taken aback that she did not have my telephone number, especially because I was next of kin. To me, for everyone's safety, they need the next of kin's details in case something goes wrong. I gave her the telephone number and I thought then that I was going to contact Dean. That phone call was meant to be set up for

the 4th. Obviously Dean passed away on the 4th, so that phone call never happened.

As for family contact before or even after things started happening with Dean, I do not think we were allocated a family liaison officer. A family liaison officer then told me that Dean had taken his own life. I was by myself—well, I had my mum with me—and I said, "How am I meant to tell Dean's mum and dad?", because we were not there together. They were at home. They said that that was not in their job role and that their duty went no further than telling the next of kin. I had to go round to Donna and Mark to tell them that their son had taken his own life. I was with my mum, who was obviously in a state, but I was also with my son, who was 18 months old. So I was trying to deal with all of that.

We had contact from the family liaison officer telling us to go to Chelmsford prison after Dean had taken his life to meet the governor and to see Dean's cell. After that, I had no other contact from the family liaison officer. I have only just received a letter from the Chelmsford prison governor, after our meeting with Liz Truss. Up to that point I had had nothing. We still got no apology. It was more a letter of condolence.

Donna Saunders: When we went into the prison after Dean had died we walked into the governor's office and she said, "Oh, I am so sorry for your loss. What a surprise". Yes, I had the same reaction as you.

Mark Saunders: We just looked at her and said, "Surprise?" She is no longer the governor there. We were told that she resigned her position to move on and that it was within two weeks of the PPO launching the investigation.

Clare Hobday Saunders: Within two weeks of Dean passing away.

Mark Saunders: There is a new governor in there now.

Q62 **Baroness O'Cathain:** Just one very quick question. How many staff dealt with Dean from the time that he first went in there to the time he died? Was it the same two or three people, or was it a team, or just whoever was around?

Clare Hobday Saunders: It was a mixed bag. There was no consistency among the people who were looking after him. There were people being pulled from other wings—as well as these ACCT reviews—just popping their heads in to see if he was okay. There was no consistency in the staff looking after him.

Mark Saunders: This took place over Christmas, so the staffing rotas may have changed.

Donna Saunders: We had been given the names of people to contact to ask about him. So we were trying to speak to the same people when we phoned up.

Clare Hobday Saunders: But you could never get hold of the same person.

Chair: So you just think they were fobbing you off as the family?

Donna Saunders: I personally feel like we were lied to from start to finish.

Chair: Just to keep you at bay.

Mark Saunders: Yes. It is like I was saying about the phone calls. They told Clare that he had been asking on the Sunday before he died. Then once the PPO report came through we found out that he had been asking from day one for our phone numbers.

Clare Hobday Saunders: Every single day.

Donna Saunders: In my opinion, how can you send someone to supposedly a place of safety if you know the track record? Like I said, I did not know the track record of Chelmsford or anything about prisons at all. How could you send someone there, as a place of safety, knowing its history?

Mark Saunders: The day before he died there are three entries in his ongoing report. The top entry is from the prison chaplain, saying that Dean had requested to see him to talk about funeral arrangements. That is the top entry, so whoever wrote the next would have seen this top one. The next entry under that was that Dean had self-harmed and had scratches on his arms. This was played down in the entry as Dean having shown the scratches and that it was irritable scratching because he could not sleep—bearing in mind that Dean died the next day and the coroner has described these injuries as self-harming cuts by a razor-type instrument. That entry is underneath the chaplain's one. The third entry was that Dean had requested a lawyer because he wanted to speed things up and had asked for a lethal injection. These are the three entries in his ongoing record the day before he died, yet no one thought that these were triggers, flags, alarms. No one thought, "Let's review this, get the ACCT and get him back on constant watch".

Clare Hobday Saunders: No one thought they were relevant at all.

Mark Saunders: During the inquest we asked people, "What did you think at the time?", and they basically said, "I think I did my job".

Chair: Makes you wonder what you would have to be doing.

Mark Saunders: Yes, and all the time they were being told that he would take his life.

Donna Saunders: The one who had taken him off constant watch sat in the court room and said, "I wouldn't do anything differently".

Mark Saunders: She was asked, "In hindsight, would you do anything differently?", and she said no.

Donna Saunders: I find that really scary.

Q63 **Ms Karen Buck:** This is all very difficult to listen to. You have talked about how you feel that the decision to move to a half-hourly observation was driven by shortage of staff or money. On some of these other aspects that you have just described, about how Dean was looking to contact you for example, do you feel, or did it come out in the inquest, that the failure to respond to these things properly was because there was nobody there in charge of responding, or that too many people were involved, or that people were not trained to understand their role, or something else?

Mark Saunders: Regarding the phone calls—

Donna Saunders: Sorry, just to interrupt you for one minute, when the prison governor came in, he said regarding the phone calls that it was as easy as turning on a light switch. You do not need to train somebody to do that.

Mark Saunders: That was in the inquest. Normally when you go into prison there is a procedure in place where they obtain these numbers. Because Dean was diverted straight into the hospital wing, that bit was missed out. I believe it is possible that they did not really know—they were unsure. As I said, their normal running routine was questionable, so with these extra tasks maybe they did not know. It seemed through statements and interviews that they were kind of, "I'm going off duty. You'll have to ask the day staff".

Clare Hobday Saunders: There was a lot of passing the buck. A lot of the entries showed that when Dean had asked for a phone call, they said, "Okay, ask the prison officers in the morning. They'll do it". There were quite a few examples where they said, "This person's going to do it", but that person said, "Oh no, this other person's going to do it".

Mark Saunders: Yes. It was passed along.

Clare Hobday Saunders: It is as if no one understood the full extent of their job role. Facilitating a phone call is not hard, but no one, even those who were performing their whole job role, would go that little bit further to make it happen. He had also asked to write a letter. Dean was dyslexic, so he said, "I need a little bit of extra help just to be able to write it". It seemed that even that was too much to ask for.

Ms Karen Buck: One would hope, certainly when someone has been identified as vulnerable and at risk, that there might be an approach that says that if someone requests communication with their family, someone will take responsibility for ensuring that that happens, but it did not happen.

Mark Saunders: No, but you would think that. During the inquest we were waiting for someone to take their seat and say, "I did my job, I did it well and I went that bit further", but they all failed us, all of them.

Ms Karen Buck: People should not need to be trained for some of that basic work, I understand that, but dealing with someone in the middle of a mental health crisis—

Clare Hobday Saunders: Their training was not up to date.

Mark Saunders: Yes, exactly, the training is not up to date. They are not fully aware that other options are available to resolve these problems, and I think they kind of get into a routine. I do not know if they become cold or numb to it all because they see it so often. I do not know if they are just thinking, "We've only got to deal with him for a little while, because he's on emergency and he's tagged for transfer so he's not going to stay here". It seems as if it is all just ticking over.

Donna Saunders: Even with resuscitation, there should be no hesitation in that. If you do that sort of job, you should be in there straight away. Did they do it? No.

Ms Karen Buck: Why do you think that is?

Donna Saunders: They panicked.

Ms Karen Buck: Is your understanding that prison staff would normally be expected to have the skills to attempt resuscitation?

Donna Saunders: For the amount of deaths they have had in the prison, I would hope so.

Clare Hobday Saunders: There was a nurse on the scene as well. Even though it was a prison officer who discovered Dean, a nurse also came along. From the moment Dean was found to resuscitation starting, there was a nine-minute delay.

Mark Saunders: And the people who were there to start with were capable of doing it. They said they panicked. The statement from the other officer who met them at that nine-minute stage says he came into the room and said, "What's going on?", and the other officer said, "He's gone". The first officer said, "You've still got to try", but by then it was nine minutes later.

Ms Karen Buck: In terms of your general sense of the prison, and knowing as we do that there is a lot of news around at the moment about conditions in prisons, staffing, psychoactive drugs and other things, and in the wider sense of the experience that you had with the prison, did you get a sense that there were other problems, such as overcrowding and staffing?

Mark Saunders: That is a bit hard for us, because he was always on that medical wing and it is a small unit, and you have tend to have compatible staff there. At the inquest we asked one of the directors of Care UK, which was supplying care in there, "Do you feel that you supply adequate care?" Their response was, "We fulfil our contract". That said it all to me.

Ms Karen Buck: Do you think that was a legalistic defence of themselves, that that was what they had to say?

Mark Saunders: No, I think it was a case of, "We do the minimum we have to, and then that's it".

Q64 **Lord Trimble:** Excuse me for mentioning this. This all happened over Christmas and the new year. Do you think that was a factor in the shambolic way the staff behaved?

Donna Saunders: Yes. The psychiatrist who was meant to do the second assessment was on leave and not due back until 4 January. There is an out-of-hours number and they could have got someone else in—they could have got a GP to do the second one—but they did not know that.

Mark Saunders: Yes, Christmas was a big factor.

Donna Saunders: He was not assessed, so he was not moved. The bed was waiting for him.

Mark Saunders: Normal procedures were delayed because of closures, holidays and so on. As Donna said, there were other options. You have to contact the Home Office, I think, for the warrant once someone gets a place, but that closes down over Christmas. There is an out-of-hours number and the staff could have arranged it over the phone, as they have in the past, and then caught up with the paperwork later on. Bearing in mind that Dean was earmarked as an emergency transfer, all this delaying was simply because people did not know that those other options were there. That is what came through at the inquest.

Donna Saunders: Whether they would have used them if they had known they were there is another story altogether.

Clare Hobday Saunders: It felt to me like none of the staff seemed to grasp that not only for Dean but for every other prisoner in Chelmsford prison and in prisons all over the UK, Christmas is going to be one of the hardest times when they are inside. There is no visiting on Christmas Day, Boxing Day and, I believe, New Year's Day. Those are three days when they are definitely not allowed to see their family, where normally they can see them with no restrictions as long as they can get a visiting appointment. For every single prisoner in there, Christmas is going to be that little bit harder. To us, the fact that there was no psychiatrist for 11 days during the Christmas period while Dean was in there felt like they were saying, "Mental health goes away for Christmas". To me, though,

mental illness would only get worse over Christmas, because prisoners cannot spend it with their family, and Christmas is a family celebration.

Q65 **Lord Woolf:** Could I just say a bit about my background? I did a report on prisons after there were riots at Strangeways, so I am very conscious of the sort of problems that you are talking about, and I am afraid they are widespread. Besides what happened to Dean, we are interested in how we can give a report that will help to avoid this happening again so that the message gets to the Government and they take action. The task of this Committee is to look at this matter from a human rights point of view. Human rights say that the right to life is one of the absolutely critical rights. What message would you like us to give?

Mark Saunders: In this country we do not give a death sentence, but for everyone who has taken their life in prison that is exactly what they got. You talk about the human right to life; you have the right to medication and treatment, but by going into the prison system that is delayed. In normal cases there is a delay of 14 days—at least it is supposed to be 14 days, but it always seems to take longer—before people can start getting their treatment. If they were put straight into a secure hospital, treatment would start from day one. It delays their treatment.

Donna Saunders: They are denied treatment, basically. He was in there for two and half weeks with no medication, no support, no family support. They took all his rights away, everything.

Clare Hobday Saunders: He was screaming out for help. He was telling them that something was going to go wrong and he was scared. He knew he was going to take his own life. He had asked them to take stuff out of his cell just so that he would not do something. What more could they have done? We were screaming at them that he was going to do something and he was doing the same. I think this is across the board, but we feel that Dean was saying, "I'm going to do this, I'm going to do that", but they did not take it seriously because it was coming from his mouth. I feel that he was never given the right to life, because even when he was asking for help it was not given.

Q66 **Lord Woolf:** You have explained the huge difficulties that existed. Looking back on your experience, do you think more precautions should exist to prevent people with his problems from being in prison at all? Because prison is not the right place.

Donna Saunders: Yes. I feel he was badly let down by SEPT. As I said, they had formed an opinion when he went to Rochford but they changed their mind on that overnight after he had got worse. The only reason I can see for that is that there was no bed.

Mark Saunders: The pathways are there to try to deflect them from prison. We were told, "This is good practice, because we put them in a place of safety"—although we know it is not—"where we can observe and

reassess them, sort stuff out and jiggle things around, and then we can place them". That is meant to have become "good practice", but it is not. It may have become common practice, but it is certainly not good. The pathways are there to deflect them. They should have looked at out-of-area beds or private sector beds, but they never exhausted all their resources.

Clare Hobday Saunders: There are no pathways set in stone for different situations where people end up in a police station for them to go straight to a psychiatric hospital. The pathway there is not correct, and the pathway of diverting out of the prison and going into a psychiatric hospital is not there either. Those are two massive pathways, but it is a big grey area and they are not set in stone. No one really understands what the pathway should be.

Lord Woolf: If neither pathway is working, presumably you are saying that there is a very heavy burden on the prison service to ensure constant observation.

Mark Saunders: It was clear to us that he was unwell. Although we were told that this was good practice and it has always been done, the prison staff were telling us, "We've never seen anyone as ill as that".

Clare Hobday Saunders: They could not understand why he was there. Not only the medically trained staff but every single prison officer said, "This man is seriously unwell. Why is he here in the first place?" If it is best practice that everyone who goes into the police station goes into prison, surely the staff would have more interaction with that. If on the other hand they are saying, "Why is he here?", then clearly that is the only way.

Donna Saunders: If that happens—if it is good practice that they go from the police station to the prison and then get assessed—why is the country paying for an assessment to be done in prison, when an assessment is not done in the first place because it is good practice to send them to prison?

Mark Saunders: The predetermined outcome will be that he goes into the justice system. Why are we spending money on these assessments if the system is just going to send them to prison anyway? We know that is wrong.

Q67 **Amanda Solloway:** My role is rapporteur to the Committee on human rights and mental health. I am just so grateful that we are doing this inquiry. My cousin took his life at a very young age, and it was absolutely tragic to see the devastating effect that that has on a family, so I completely understand that. What recommendations could you give to this Committee? Could you please perhaps give a summary of what you have said?

Mark Saunders: I think the PPO does a really good job. Our PPO report was really in-depth, looking at particular things. So it does a good job and gives good recommendations, but, as we all know, those recommendations are not enforceable.

Donna Saunders: That needs to change.

Mark Saunders: I think that needs to change. They need to become enforceable. Not only should things be put into place but they should be continuously practised. Maybe a deadline could be given by which they had to come in. I mean, in any other industry someone would come in and say, "This is wrong. Here's a recommendation and it has to be done by that date or we close you down". There has to be some sort of penalty or something if they do not get things into place by a certain date. The situation has to be, "Here's our recommendation. This seriously needs to be done. We'll give you reasonable time to respond and put it into place, and then we need to see that it is continued to be practised".

Amanda Solloway: I am thinking of recommendations that you could make. In other words, if we were going to recommend some changes that should be made, is that the single most important thing?

Mark Saunders: No.

Donna Saunders: That would definitely be the pathway.

Mark Saunders: I believe it has got so far out of control now. People have fallen into a routine and a rut. They need to go back and get the basics right, like training.

Donna Saunders: And accountability.

Mark Saunders: Yes, that is a big thing as well. At many inquests into previous deaths, the establishment steps forward and we hear that famous line, "We've failed. There are lessons to be learned and we will learn from this", but that is it. There is no accountability. Maybe someone should be held responsible on that ground level, on that floor, if they have done their job wrong. We are bus drivers. If we mount the kerb and knock someone over, we know our licence will go.

Chair: So it was not even a case of passing the buck—the idea of "passing the buck" is that someone passes it to someone else—but rather that there was just a complete absence of responsibility or accountability.

Donna Saunders: Yes. On the whole, the prison would go, "We failed. Here's some money. Go away".

Mark Saunders: And, "We'll learn from the lessons".

Donna Saunders: But the people in that prison who have not done their job, the people who took him off constant watch when they were not

qualified, who lied over and over again, who did not check his records when they were supposed to—what happens to them? Nothing. They just carry on going to work.

Clare Hobday Saunders: "Lessons to be learned" seems to be such an overworked statement that it is not important any more.

Donna Saunders: Exactly. My son is not a lesson.

Clare Hobday Saunders: They should actually be learning those lessons, but instead they just say it so that people will go away. That happens again and again. Those lessons are not being learned. For me, the PPO's investigation was fantastic, but that bit of paper is almost irrelevant. They will look at it and say, "Yes, we'll sort it out", but they will not. It seems to be a tick-box exercise: "We've have the PPO investigation and we'll say we'll do this, this and this. They won't come back and check, but next time it happens will say, 'There are lessons to be learned'".

Amanda Solloway: So you are saying, when you talk about people all the way through the system, that it is as if the pathway is failing at every level.

Mark Saunders: It really does need going back to the basics, stripping down and relaying. Staff should be clear about the paths, opportunities and directions that are open to them to get these people into the places where they are going to get treatment and support and get well.

Donna Saunders: Someone as ill as Dean did not deserve to be in prison. That will for ever be on his death certificate. He had never been in trouble with the police.

Chair: He was ill.

Donna Saunders: He was ill, but now for ever more on his death certificate it says, "Chelmsford prison". It is wrong.

Chair: You have explained the situation to all of us so, so well, and it is so important for us to understand. You have done him proud by explaining what sort of young man he was and how hard you fought—as people who have not had any experience of the prison system because you are not that sort of family—and how frustrated you are. I hope that we can take forward the frustration you feel by making our recommendations. I very much get your point, Clare, that you are not interested in another set of lessons learned or recommendations. It absolutely has to be action.

Clare Hobday Saunders: The reason why we are in a position today to come and speak to you is that we are fortunate in the sense that we were directed towards the inquest and were able to be legally represented at

the inquest and to have that team behind us. We are nobodies. If we did not have that, we would not have known the questions to ask.

Mark Saunders: We could have walked away.

Clare Hobday Saunders: Yes. We would not have known what to ask or whether the answers they were giving us were the wrong answers. Throughout the whole process, it was all obviously coming from a professional's mouth; you take that at face value. If we had not had the legal representation, we would never have been able to get even half of the answers that we were asking for. Not all families get that opportunity. We were just fortunate.

Donna Saunders: I believe that they are the ones who have done wrong. They have admitted now that they were wrong and that they neglected Dean. They get their representation paid for them. Why did we have to fight and pay ourselves? We cannot afford it. We do not have loads of money. We are just working-class people. Why should we have to feel like we are the ones in the wrong and it is all given to them?

Mark Saunders: Especially when you know from looking at the reports and the findings that there were so many failings. They could not do anything but say, "You know what? You're right. We were in the wrong". Why not stop that and stop it early? We looked over to our left and there was a bank of solicitors and lawyers, there was Essex Police, the prison, and Care UK.

Chair: All with their lawyers.

Mark Saunders: Yes, that is right.

Clare Hobday Saunders: We felt like we were standing trial.

Chair: So the system was defending itself, having failed to defend Dean. What will stay with all of us after your evidence is you saying, Mark, that we do not have capital punishment in this country but that what happened to Dean was that he suffered a death sentence.

Thank you very much for your courage to come here and speak to us. We will not forget what you have told us. We will take it forward into our proposals. If there is anything further that you want to add, you can do that. You have done us a great service.

Donna Saunders: We said that we fought and saved him that night at home, but part of us wishes we had not, because all we did was to get him locked away for two and a half weeks on his own, with no support and no family contact. He just suffered for two and a half weeks until they let him do it again. At least if he had done it at home we would have been with him.

Chair: That is a terrible thing for a mother to feel.

Donna Saunders: That is how it is. That is all they did. They shut him away for two and a half weeks, away from everybody, and then let him do it anyway, on his own.

Mark Saunders: He went from being a stay-at-home dad to a bare concrete cell with no contact over Christmas, with no support and no medication.

Donna Saunders: And feeling abandoned.

Mark Saunders: No one should have to go through that.

Chair: Thank you very much indeed. If you would like to stay for the rest of the session, you are very welcome to. On behalf of all the Committee Members, I thank you very much.

Mark Saunders: Thank you.

Examination of witnesses

Ms Sheila Waplington, Ms Marlene Danter, Ms Deborah Coles and Selen Cavcav.

Q68 **Chair:** I particularly thank you, Marlene and Sheila, as Diane Waplington's aunt and mother, for coming to talk to this Committee against the background of such a tragedy. Thanks as well to Selen and Deborah from INQUEST, who have come alongside you. I start by asking you the question about what actually happened, in your own words, to lead to Diane being in Peterborough prison and what happened to her there?

Sheila Waplington: Diane had been under the Mental Health Act for about 14 years and she had been sectioned three or four times. She would do things. She would never hurt anyone, but she would change in a flash. This particular time, she had set fire to her bed. It was put straight out. One of the nurses at the hospital that she was in said to her, "If you do anything else, you'll go to prison because you're not mentally ill. You'll either go to prison or you'll be out on the street". Of course, she panicked. She was institutionalised, so she did not know anything else. She set her bed on fire again and that is how she ended up in Peterborough prison.

She should never have been in prison, because she did not hurt anyone. It was just where they stuck her. They just took her. The judge ruled on the night that she be taken in. I got one phone call from Diane to say, "I'm in prison", and never heard another thing until they knocked on my door and said that she had committed suicide.

Q69 **Baroness Hamwee:** You may have heard me say before that it might seem rather odd to ask the question, when we can kind of read between the lines, but we would like to hear from you how you think the prison

authorities should have involved you.

Sheila Waplington: For a start, the prison and the mental authorities both let me down, as far as I am concerned, because I never got a phone call to say that she was being moved. Although over the 14 years she had been moved all over the country, I never got a phone call to say where she was.

Marlene Danter: Or why she was being moved.

Sheila Waplington: Yes, or why she was being moved.

Marlene Danter: Or whether she had been sectioned.

Sheila Waplington: The only information I ever got was from Diane herself. We heard nothing from the prison authorities at all until they came knocking on my door and said that Diane had passed away.

Q70 **Baroness Hamwee:** We heard from the Saunders family about the problems of contact. Did you find similar problems? You say that they did not contact you.

Sheila Waplington: We had no contact whatsoever.

Baroness Hamwee: Did you hit a brick wall when you were phoning to inquire how she was? Was it a similar experience?

Sheila Waplington: It was a short time for Diane. She was only in there for a couple of days. All I did was speak to Diane. I did not even know that I could ring the prison.

Baroness Hamwee: That says quite a lot in itself.

Marlene Danter: We never knew how to contact anybody, because no information was ever given to us. Like Sheila said, she was never informed when Diane was moved from one place to another. There was never a contact number, or even a liaison officer. Nobody was ever appointed to Sheila in that role.

Sheila Waplington: They cannot say they did not know she was ill, because she had been in the system for 14 years. There was no excuse. She had self-harmed for 14 years, but where I think there is a difference between Dean and Diane is that Diane never meant to take her life. It was always a cry for help, and I think she was let down.

Marlene Danter: She knew the system quite well and expected that help to come.

Sheila Waplington: And it did not come.

Q71 **Ms Karen Buck:** Perhaps I should have also asked Dean's parents this question, but was there an issue about patient confidentiality in the case

of your daughter and her routes through the mental health system, and possibly in prison too, where there would not necessarily be an expectation in the care of an adult that another person would be informed about them?

Sheila Waplington: I could understand patient confidentiality if, say, Diane had said that she did not want her family to know, but she had signed to say that I could find everything out anyway.

Ms Karen Buck: Okay, that is why I am asking.

Deborah Coles: Could I provide a little context that might help your following questions? The family have already said that Diane had only been in there for three days. When she went to Peterborough prison, the mental health services had sent a detailed 22-page fax to the prison documenting Diane's history, and what became clear at the inquest was that a number of the staff had not seen, or had not read, that information.

Also, while she was in Peterborough prison for those few days, she self-harmed on five separate occasions by tying ligatures and by attempting to choke herself by swallowing tissues, but at no time did they review her suicide and at-risk status. Then she ended up throwing some hot water on a prison officer, which was a manifestation of her behaviour. She had been diagnosed as having personality disorder. That might be an issue that you might be interested in: the treatment of people with personality disorders. She then ended up getting punished, which is something that we see quite frequently. She was treated as a discipline problem and ended up in segregation, so she was even more isolated and vulnerable as a consequence.

Baroness Hamwee: That is a repeat of what happened when she set fire to the bed.

Sheila Waplington: She asked if she could speak to the Samaritans. She was not actually denied it, but the answer was that they had no batteries for the phone, so she could not speak to the Samaritans. Yet she had asked if she could speak to them. She was crying for help but nobody was listening. Peterborough is one of the worst for this.

Marlene Danter: Peterborough is a supposedly modern prison.

Sheila Waplington: It is worse for women in there.

Marlene Danter: Precisely. It is supposed to be one of the most up-to-date, modern prisons, with all the facilities.

Sheila Waplington: She was also supposed to be on 15-minute watch, but you will never make me believe that it was done—or was it 12 minutes? According to the inquest, they were supposed to have checked on her. Within 12 minutes, Diane is supposed to have put a plastic bag

around her head, tied it and suffocated on it. Then they came in and found her and tried to resuscitate her. All this happened in 12 minutes, and she died.

Marlene Danter: The first prison officer who tried to resuscitate her panicked.

Sheila Waplington: Yes, she panicked.

Marlene Danter: She had no idea what she was doing. I am sorry, but if they work on a mental health ward, surely they should be at least first aid-trained for that reason alone. They should not be panicking because they do not know what to do.

Sheila Waplington: They were in the mental health section.

Marlene Danter: She was in the mental health section of Peterborough.

Baroness Hamwee: So she sets fire to her bed and is told, "You're not mentally ill, so it's an offence".

Sheila Waplington: Even though she had been in the system for 14 years.

Baroness Hamwee: And she throws hot water over someone and is told, "You're not mentally ill". But they knew.

Deborah Coles: In fact, we have the details of the bail hearing when she was in front of the judge and was refused bail. I have it here. She was told, "You are refused bail because you are likely to offend. This is because of mental health issues". That was at the actual bail hearing. It is there in black and white. Like Dean, you have someone who is criminalised for being mentally ill.

Sheila Waplington: And like Dean, she had never ever been in trouble. The only person she ever harmed was herself.

Q72 **Lord Woolf:** We are here, as you know, because we are interested in human rights, and the human rights of prisoners are as important as anyone else's. The overwhelmingly important human right is the right to life. Tell me, where do you live? I am afraid I do not know. How far is it from Peterborough?

Sheila Waplington: I live in Derby. It is about two hours' drive.

Lord Woolf: And would I be right in thinking that because she was a woman, the only possible placement where they could put her in a secure position that was available if there was no hospital that could do it was Peterborough?

Sheila Waplington: That is what they said, yes.

Lord Woolf: Do you know of anywhere else where they could have placed her?

Sheila Waplington: Apparently they were asked if they would find her a bed in a hospital, but they said no, they could not find one.

Marlene Danter: She was in already a hospital to start with, just not in a secure ward. So she had a hospital bed, but not a secure one.

Lord Woolf: My colleague Lord Trimble points out that when she was in that unit, she had a good experience.

Sheila Waplington: In the Farndon Unit, yes. She seemed to do really well. I am not going to say that she would ever have got out. I do not know, but she did really well. She did not self-harm quite so much. She seemed more settled.

Marlene Danter: She was more alive in herself.

Lord Woolf: Can you help us on the difference between the two settings in which she was kept: the one where she took her life and the one she had been in beforehand?

Sheila Waplington: The Farndon Unit was high-security, so she could not just walk out. I think it was all-female as well, and I think that can mean there is more understanding.

Lord Woolf: Whereas Peterborough is a huge prison but with very a small unit of females.

Sheila Waplington: Yes, and at the end of the day they are trained for prisoners, not for mentally ill people.

Q73 **Lord Trimble:** Is there any advice you would like to give to other families who may be in similar situations?

Sheila Waplington: Yes. Now that we know better, we would say: argue your point all the way. For a start, try not to let them get in there. Stop it before it starts.

Lord Trimble: It is coming out quite clearly that prison is not the right place.

Sheila Waplington: Prison is not the place for mentally ill people. It is a trigger.

Marlene Danter: In our case, we had never even heard of the ACCT until the inquest.

Sheila Waplington: We had not heard of a lot of things until the inquest, even Diane's funeral requests.

Chair: So it goes without saying that you were not invited to any of the ACCT reviews or to contribute or share your experience.

Marlene Danter: No, nothing. They were working off two systems with Diane, the ACCT review and a separate mental health system. Although they had access to the ACCT, they did not have access to the other part of the system, which I believe is where the fax went. It went into a file that they did not have access to.

Sheila Waplington: One hand did not know what the other hand was doing. Like I said, the first I heard of her funeral requests was at the inquest. I felt sorry for the poor coroner, who was reading them out while I sat there in shock.

Marlene Danter: We did not know anything about it, so we could not carry out her requests.

Sheila Waplington: And now I feel like I have let my daughter down, because I did not adhere to her requests, because I knew nothing of them.

Chair: What comes over really strongly from what you are saying is that your daughter was very ill and had been for a long time, and you were the people who cared most in all the world about her, yet there was no engagement with you or anything at all to make you part of finding a way forward for her.

Deborah Coles: Do you mind if I just say something? Yesterday I attended in the House of Lords the 10th anniversary of Baroness Corston's review of women in the criminal justice system. I was on that review panel. I attended the anniversary with great sadness and frustration, because I had really hoped that as a consequence of the recommendations of that review 10 years ago I would not have to sit alongside a family whose daughter had been failed yet again by the criminal justice system.

Last year, we saw more women's deaths in prison than in any other year in history. Diane was someone who we all accept should never have been there. Where she was most well and dealing best with her personality disorder was in a dedicated, female, low-security environment, where she was getting support and help. We invest a lot of money in prisons that further damage women, but in fact these units are the facilities that women need. In terms of the human rights framework that you rightly point to, that is where we have the real problem. These are precisely the places where women like Diane need to be.

Lord Trimble: From the notes we have on the case, it seems to me that the crucial point at which she got diverted down the wrong path was at Bassetlaw hospital, where her mattress was set on fire. Our notes just say that Diane was charged with arson for that. Who in Bassetlaw

hospital was responsible for putting her down that line and treating her that way? Someone must have decided to do that.

Marlene Danter: She was not seen by a psychiatrist at that point.

Lord Trimble: She was not being seen by psychiatrist?

Marlene Danter: She was under a psychiatrist at that time, but at that time the police were called and I believe the psychiatrist was on leave.

Selen Cavcav: Just before she went into prison.

Marlene Danter: Just before she went into prison he was on leave, and they did not call in the duty one.

Lord Trimble: So the hospital called in the police, but they did not call a psychiatrist.

Deborah Coles: Yes, and it was criminal damage and arson that she ended up being charged with. She was then refused bail on the basis that she might reoffend because of mental health issues.

Lord Woolf: Did the judge have any psychiatric report when he refused bail?

Deborah Coles: No.

Baroness O'Cathain: Had she been regularly under a psychiatrist before she actually did this in Bassetlaw hospital?

Sheila Waplington: Yes. Like I say, she had been for 14 years. She had been in the system and under psychiatrists.

Baroness O'Cathain: Were they always the same? Did she know the psychiatrists, or were they chopping and changing?

Sheila Waplington: Because they chopped and changed, she would just get to know one and then either they would move on or Diane would be moved on.

Lord Trimble: We mentioned the Farndon Unit earlier, where Diane's condition improved to the point of moving into supported housing. Then her notes just said, "and eventually ended up back in hospital".

Marlene Danter: Diane could not cope with being there.

Lord Trimble: Surely she would always have had a single psychiatrist who would have been treating her at the Farndon Unit. In that situation, no major decision should have been taken with regard to her treatment without clearing it with the psychiatrist whose care she was in.

Sheila Waplington: She did not have one. She only had what she was allocated.

Marlene Danter: Well, she did have one, but they did not contact him.

Sheila Waplington: And that was only in that hospital. Every time she changed hospital, they changed the psychiatrist. She did not have a phone one.

Q74 **Jeremy Lefroy:** I wondered if you had any specific recommendations that you would like the Committee to make.

Chair: How could things have been different?

Marlene Danter: The family should always be informed about what is happening: when they are being moved and why. There should be contact with the family.

Sheila Waplington: It comes to something when you do not know where your own child is. She had children. I know Dean had a little boy, but Diane had grown-up children—her son is 25—and they still did not know. No one informed them, even though she had me down as the next of kin.

Jeremy Lefroy: On the point that Karen made earlier, I have found in cases in my constituency that patient confidentiality is sometimes used as a way of not keeping families informed.

Sheila Waplington: Yes, that is exactly what we found. Diane had given permission for me to know everything. She had signed the form and everything, but still no one informed me of anything because of patient confidentiality.

Jeremy Lefroy: How was that form kept? Was it always where she was?

Marlene Danter: Apparently it was always kept with the ACCT papers, which supposedly followed her around.

Jeremy Lefroy: Thank you. Are there any other specific matters?

Sheila Waplington: Yes, training. Again we come back to this question. If you are going to use prisons for this, surely people should be trained, as Marlene says, at least in first aid. Panicking and running around like a headless chicken, which is what the lady who found Diane did, does not instil much confidence in any of us.

Marlene Danter: Wherever she goes, there should be one designated person. Although Diane had a designated nurse, when she went off shift there was no one then to hand over to. No one does 24-hour shifts.

Sheila Waplington: This also proves that no one listens to you. Diane died going on three years ago with a plastic bag, yet when I met Dean's

parents, whose son died only a year or so ago, they told me he also tried to use a plastic bag. We had said that the one thing we wanted to tackle was why they had plastic bags in their cells.

Marlene Danter: We were told that there had been no other cases, but there had been some in Manchester. Although there had been no cases in that prison specifically, there had been other cases.

Sheila Waplington: The bags are still there, so no one is listening anyway.

Jeremy Lefroy: I had the case of Stafford hospital in my constituency. We had a public inquiry, as a result of which there have been huge changes in the NHS. The Care Quality Commission inspects GPs' surgeries and care homes, and many more duties have been put on the NHS for the safety and quality of care of patients. I had a Private Member's Bill a couple of years ago that resulted in the Health and Social Care (Safety and Quality) Act, and one of the things we put in there was that there was a duty to share information in the interests of the patient. I do not know if there is such a duty in law in the interests of people held in institutions such as prisons or secure hospitals, but I wondered whether we should make a recommendation that there should be a statutory duty to share information.

Marlene Danter: There certainly should be.

Jeremy Lefroy: Often, as you have been saying and as the Saunders family said earlier, the case is that information simply is not shared sufficiently widely, even down to simple things such as passing on from one shift to another.

Sheila Waplington: And moving them. As I say, I would arrange to go and see Diane, but I would get a phone call from her saying, "Oh, you can't, mum". "Why?" "I'm in Yarmouth." She had just been moved, but none of us knew.

Marlene Danter: If she had been ill, she could have been there for a month before she contacted Sheila. Sheila did not actually know where she was at any one time. On all levels, that is so wrong. You should always know.

Q75 **Lord Woolf:** This may not be something that you can answer, but if you can it would be very helpful. With someone who is known to have the problems that she had, would it be a help if someone in their family was always provided with details of one person who they could get in touch with within the prison who, if he or she could not directly answer or do anything, could find out and feed the answers back? Often the relatives will be most aware of the state of the prisoner—actually, it is much more important to call them the patient.

Sheila Waplington: Yes, exactly, because that is what they are.

Lord Woolf: So they would have a contact point for information going both ways.

Sheila Waplington: You would have one in a hospital, wouldn't you?

Lord Woolf: Unfortunately, we know that the state of our prisons is such that not all the people who should be in a hospital can be there. Special steps need to be taken for the category of patient I am talking about who happens to be in prison, so that they still get the sort of protections that are provided by hospitals.

Deborah Coles: As part of Lord Harris's review, which I was also involved with, we facilitated meetings for him to hear directly from bereaved families. The frequent complaint from families whose relatives had died was precisely that: trying to phone the prison to talk to someone, share their concerns or indeed get feedback from the prison was absolutely impossible. His recommendation was for a family helpline, but that was one of the recommendations that the Government rejected. There is a real problem with how families keep in contact with people in prison and how they access that information. It was an important recommendation.

Lord Woolf: And it is well known that female prisoners are often a long way from their family, so it is very difficult for the family to keep contact.

Sheila Waplington: That is right.

Lord Woolf: Unfortunately, because the number of female prisoners is so much smaller, the places they can go to are often long distances away.

Marlene Danter: So are the hospitals. Some of the mental health hospitals are quite a distance, because there are so few of them.

Baroness O'Cathain: Is there a clash between patient confidentiality and actual contact with members of people's families? I ask that because I have had the experience of trying to find out about a very dear friend of mine. I tried everything, but there was no way. In fact, I was told that she was recovering in the recovery ward at the time when she was dead. But you can understand why, because they do not want journalists ringing up if someone has been in a car accident or something like that.

Chair: But it sounds like Diane had signed the form for you to be kept informed.

Sheila Waplington: Yes, that was not an issue at all.

Chair: So, basically, do you think that the pathway went wrong? When the bed was set fire to, the psychiatrist not being on and so on, the first issue was that the pathway was wrong and that she went somewhere that was not suitable for her. Another issue is that there was no proper

family contact. There is an Article in the European Convention on Human Rights on the right to family life, and that is your right as well as hers, so we should very much focus on that. Then there is the point about people not being trained to deal with eventualities and therefore panicking rather than responding appropriately. Then there is the issue of a line of accountability, which would knit in with contact with the family. There should be some kind of key worker. That might change from time to time with people not being on duty all the time, but if someone is identified as vulnerable there needs to be a key worker there.

Sheila Waplington: Also, I think the family should be involved and talked to. If someone had spoken to me, I would have said to them, "Stop letting her out and putting her in these halfway houses, because she's only going to make herself go back". She could not cope with the outside. They were trying to rehome her, but she would just go back. She was institutionalised and could not cope with the outside world, so when they put her in the halfway houses and she was left to her own devices, she would do something that would get her back inside. But no one listened—it was like they knew best.

Chair: I thank you very much for coming and speaking to us about your beloved daughter. Please pass on our condolences to her children as well. Thank you for, in your grief, coming and talking to us about what happened for the sake of us understanding what needs to be done. You have spoken to us very clearly about what needs to be done as people who were outside the system and simply being fobbed of by it. Nothing can bring her back, but you have done us a great service.

Sheila Waplington: Hopefully we can save some other family from going through the same thing.

Chair: Thank you very much for giving us your evidence. We really appreciate it. If there is anything else that it occurs to you on reflection that you would have liked to have said—it is very difficult when we you are being asked questions by us all—then we want to hear it. You are the people who understand the most about this because you care the most about what has happened to your relatives. Thank you very much indeed on behalf of the Committee for giving evidence to us today.

Sheila Waplington: Thank you.