

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Ms Nicola Cope a prisoner at HMP Foston Hall on 29 November 2016

A report by the Prisons and Probation Ombudsman

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*



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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.

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

Ms Cope died in hospital on 29 November 2016, having been found hanged in her cell at HMP Foston Hall. She was 59 years old. I offer my condolences to Ms Cope's family and friends.

Prison staff began suicide and self-harm prevention procedures four days before Ms Cope's death when she harmed herself and began to refuse food. Ms Cope was segregated on the same day, with little recognition that this should be exceptional for someone at risk. I am concerned that several important safeguards, designed to protect such vulnerable prisoners from the isolating and restrictive impact of segregation, did not operate effectively. No one assessed Ms Cope's mental health after she was segregated, and the review board (which was not multidisciplinary, as national instructions require) did not consider whether there were still exceptional circumstances that required her segregation.

Ms Cope's case reviews, which should have considered her current risk of suicide and self-harm and sought ways to reduce that risk, were not multidisciplinary and did not identify and put in place plans to reduce risk. Overall, I am concerned that staff underestimated Ms Cope's risk of suicide on the morning of 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

August 2017

Contents

Summary	1
The Investigation Process	3
Background Information	4
Key Events	6
Findings.....	12

Summary

Events

1. On 22 May 2015, Ms Nicola Cope, a transgender prisoner, was sentenced to 16 years in prison for historic sexual offences, which she had committed as a man. She had subsequently had gender reassignment surgery and was tried and convicted as a woman. Ms Cope spent the whole of her time in prison at HMP Foston Hall. Prison staff managed her under suicide and self-harm prevention procedures (known as ACCT) several times. Ms Cope told staff that she had taken an overdose around 18 months before she went to prison and, in October 2016, she said she had aborted an attempt to hang herself.
2. On 18 November, a prisoner told staff that Ms Cope had sexually assaulted her. Staff reported the allegation to the police. That night, Ms Cope cut her arm, said the allegation against her was false, and wrote a note in which she implied that she intended to take her life. Staff began ACCT procedures.
3. On 19 November, a supervising officer led the first case review but no healthcare representative attended, a mandatory requirement. On the same day, Ms Cope began to refuse food. Later that afternoon, an operational manager segregated Ms Cope in her cell on B Wing because of the nature of the allegation against her and the ongoing police investigation. There was no mental health assessment within 24 hours, which is required when a prisoner subject to ACCT procedures is segregated.
4. On 21 November, another operational manager chaired a review of Ms Cope's segregation. There was no healthcare representative at the review board which did not consider whether there were any exceptional circumstances that justified Ms Cope's continuing segregation while subject to ACCT procedures, both of which are mandatory requirements.
5. On 23 November, an offender supervisor told Ms Cope that her former partner had contacted the prison and said he wanted no further contact from her. Ms Cope said she had no reason to go on and that she had a plan to take her life, which she intended to carry through. At an ACCT case review held afterwards, a supervising officer concluded that Ms Cope's risk of suicide and self-harm had not increased.
6. At around 2.54pm, an officer found that Ms Cope had locked herself in her bathroom with what appeared to be a ligature over the door. She radioed for assistance, went into the cell and forced the bathroom door open, and removed the ligature. Other staff began cardiopulmonary resuscitation and called for emergency assistance. Paramedics arrived and took Ms Cope to hospital, but she died on 29 November.

Findings

7. Vulnerable prisoners at risk of suicide and self-harm should only be segregated in exceptional circumstances. We are concerned that the reasons behind Ms Cope's segregation were not sufficiently well considered or documented and there is little evidence that other options were fully considered. Staff did not

adhere to several important safeguards, designed to protect those prisoners at risk of suicide and self-harm who are segregated. These include mental health assessments and multidisciplinary segregation review boards that specifically consider whether to continue segregating a prisoner subject to ACCT procedures.

8. We are concerned that staff failed to operate a number of the key aspects of ACCT procedures aimed at reducing risk, including holding multidisciplinary case reviews and setting meaningful caremap actions. We found that staff underestimated Ms Cope's risk of suicide on the morning of her death.
9. While the response of prison staff when Ms Cope hanged herself was mostly effective, they should have called for emergency medical assistance earlier.

Recommendations

- The Governor should ensure that staff manage prisoners at risk of suicide and self-harm in line with national guidelines, including that:
 - ACCT case reviews are multidisciplinary where possible and include all relevant people involved in the prisoner's care, with healthcare staff attending all first case reviews.
 - ACCT caremap actions are specific and meaningful, and identify all of the issues identified at assessment interviews and case reviews.
 - Prisoners at risk are not held in segregation unless all other options have been considered and excluded and there are fully documented reasons to explain the exceptional circumstances.
 - Case reviews consider all relevant information that affects risk, and staff review the risk of suicide and self-harm whenever an event occurs which indicates an increase in risk.
- The Governor and Head of Healthcare should ensure that staff manage prisoners held in segregation in line with national guidelines, including that:
 - Segregation review boards include a healthcare representative and, when a prisoner is identified as at risk of suicide and self-harm, include the ACCT case manager. They should consider and record whether there are exceptional reasons to authorise continuing segregation.
 - A segregation health screen is held before a segregation review board.
 - Prisoners identified as at risk of suicide and self-harm should have a mental health assessment within 24 hours of their initial segregation.
- The Governor should ensure that all prison staff are made aware of and understand their responsibilities during medical emergencies, including that they use the appropriate emergency medical code to communicate the nature of the emergency effectively.

The Investigation Process

10. The investigator issued notices to staff and prisoners at HMP Foston Hall informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
11. The investigator visited Foston Hall on 7 December 2016. He obtained copies of relevant extracts from Ms Cope's prison and medical records, and interviewed two prisoners who knew her.
12. The investigator interviewed nine members of staff at Foston Hall in January and February 2017.
13. NHS England commissioned a clinical reviewer to review Ms Cope's clinical care at the prison.
14. We informed HM Coroner for Derbyshire 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 Cope's son, to explain the investigation and to ask if he had any matters he wanted the investigation to consider. He said that a few days before her death he had agreed to renew contact with Ms Cope. He asked what information prison staff gave Ms Cope about this and whether they considered its potential impact on her mood. Ms Cope's son said that she had previously tried to take her life and asked whether prison staff appropriately considered this information.
16. Ms Cope's son received a copy of the initial report. He did not make any comments.

Background Information

HMP Foston Hall

17. HMP Foston Hall is a closed women's prison serving courts in the Midlands. It holds up to 344 prisoners, including unconvicted and unsentenced women, young adult women under 21 years old and sentenced women, including some serving life sentences.
18. CARE UK provides primary healthcare services. There are daily GP sessions from Monday to Friday, with out of hours provision at other times. Three primary care nurses and a healthcare assistant are on duty during the day, reducing to one nurse and a healthcare assistant from 8.00pm to 7.15am. CARE UK provides mental health provision.

HM Inspectorate of Prisons

19. The most recent inspection of HMP Foston Hall was in June 2016. Inspectors reported that the number of women subject to ACCT procedures was high. They found that case managers generally knew women well and were caring and supportive. Inspectors reported that the involvement of healthcare staff in ACCT case reviews was inconsistent.

Independent Monitoring Board

20. 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 November 2016, the IMB reported that prison managers gave the safer custody function a very high priority and that they had made efforts to improve the effectiveness of the ACCT process. The IMB highlighted the high number of women on open ACCT documents, but reported a proactive approach to managing those subject to ACCT procedures, including good action plans to manage and reduce the risk of self-harm. They reported that segregation reviews were multidisciplinary and properly conducted.

Previous deaths at HMP Foston Hall

21. Ms Cope was the sixth prisoner to die at Foston Hall since January 2015, and the fourth to take her own life. Our investigations into the deaths of two prisoners in July 2015 and September 2015 respectively, found that ACCT case reviews were not always multidisciplinary and, in the latter investigation, that prison staff underestimated the woman's risk of suicide and self-harm. Our investigation into the death of a woman who died two weeks before Ms Cope found that ACCT case reviews were not always multidisciplinary, and that staff did not record whether there were exceptional circumstances to justify segregating her when she was subject to ACCT procedures.

Assessment, Care in Custody and Teamwork

22. 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. 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. 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.

Key Events

HMP Foston Hall

23. On 22 May 2015, Ms Nicola Cope, a transgender prisoner, was sentenced to 16 years in prison for historic sexual offences against members of her family, which she had committed as a man. In the late 2000s, she underwent gender reassignment surgery and, at her trial, was legally recognised as a woman.
24. That day, Ms Cope arrived at HMP Foston Hall. It was her first time in prison. Ms Cope told reception staff that she had taken an overdose around 18 months earlier. She said she had been diagnosed with depression and prescribed fluoxetine (an antidepressant). Reception staff began ACCT procedures, which prison staff stopped on 2 June.
25. Over the next 16 months, prison staff monitored Ms Cope under ACCT procedures three times and on one occasion for nearly three months. Ms Cope told staff about relationship difficulties she had with her partner in the community and with women in the prison. She once told a nurse that she had tried to hang herself in prison, although there is no confirmation of this event in the ACCT document open at the time or any of her other prison records. The mental health team assessed Ms Cope a number of times and, in July 2016, she saw a visiting psychiatrist who referred her for counselling.
26. On 3 October, prison staff again began ACCT procedures after Ms Cope said she wanted to end her life because of physical health issues related to her gender reassignment surgery.
27. On 15 October, Ms Cope told an officer that she had tried to hang herself but then changed her mind. Earlier that day, she had argued on the telephone with her partner in the community about her relationship with a prisoner at Foston Hall. (All prisoners' telephone calls are recorded and prison staff listen to a random sample. This telephone call was randomly selected by security staff.) A week later, Ms Cope told an officer that her relationship with the prisoner had finished and that she understood that the prisoner and her partner in the community were now in a relationship themselves. Ms Cope told the officer that she gave this relationship her blessing, although another prisoner who knew Ms Cope told us that she was distressed by the relationship.
28. On 1 November, a psychiatrist assessed Ms Cope. Ms Cope spoke about her attempt to take her life a few weeks earlier (presumably 15 October) and of suicidal thoughts at that time. He recorded that Ms Cope had no current intent to take her life. He prescribed a course of mirtazapine (an antidepressant).
29. Later that day, a Supervising Officer (SO) stopped ACCT monitoring. She recorded that Ms Cope said she felt much better in herself and had no thoughts of suicide or self-harm.
30. In November, prison staff reported intelligence that Ms Cope had started a relationship with another prisoner and that two other prisoners had expressed concerns that Ms Cope was taking advantage of this prisoner. As a result, a custodial manager asked wing staff to monitor their relationship.

31. At around 5.00pm on 18 November, the woman who was allegedly in a relationship with Ms Cope told a SO that Ms Cope had sexually assaulted her. The SO charged Ms Cope with the disciplinary offence of committing an assault, and referred the allegation to Derbyshire Police.

Opening ACCT procedures

32. At around 12.45am on 19 November, Ms Cope pressed her cell bell and told the night patrol officer that she had cut her right arm. The officer began ACCT procedures. Ms Cope had written a note in which she said that the allegation made against her was false and she “will not go through any more of this shit”. Ms Cope also wrote “goodbye” and “see you in hell” in the note. The night manager recorded that Ms Cope also said she had tried to hang herself. (There is no record of what she used or whether staff found a ligature in her cell.)
33. Ms Cope’s son told us that he contacted Foston Hall on the morning of 19 November as he had heard that Ms Cope had tried to take her life. (We do not know the source of this information.) He said he spoke to a chaplain, who told him this was not true. Mr Cope’s son told us that he had not had contact with Ms Cope for some time but agreed for the chaplain to pass her his telephone number.
34. At around 12.00pm, a SO assessed Ms Cope as part of ACCT procedures. Ms Cope said she had been accused of a sexual assault which she had not done, and this reminded her of her childhood when she had often been accused of things she did not do. She said she would not eat or drink. He recorded that Ms Cope’s two key issues were that she had been accused of sexual assault, and that she needed something to give her some focus, such as playing her keyboard. (Several members of staff told us that Ms Cope enjoyed playing her keyboard and that it was a useful tool to distract her from her worries.)
35. Shortly afterwards, a SO led the first ACCT case review, with another SO, an officer and Ms Cope. No healthcare representative attended. The SO listed another SO as the ACCT case manager. She recorded that Ms Cope said she wanted to kill herself by not eating or drinking, but later asked for a tea pack and milk. (There is no record of whether Ms Cope ate or drank anything else that day.) Ms Cope said that she felt low because of the allegation made against her, and she said she was innocent. During the case review, a prison chaplain joined the discussion and told Ms Cope that he had spoken to her son that morning and he wanted to get in touch with her again. The SO said that Ms Cope began to cry and they were unsure whether she was happy or upset about the news. Ms Cope said she wanted to add her son’s number to her telephone list.
36. The SO entered two actions on the ACCT caremap: for Ms Cope to discuss the allegations made against her at a prison disciplinary hearing, and for Ms Cope to add her son’s number to her telephone list. He concluded that Ms Cope’s risk of suicide and self-harm was raised (on a scale of low, raised or high) and set ACCT observations at a minimum of four per hour.
37. Around two hours after the case review, Ms Cope moved to a cell on B Wing. The Head of Security and Operations authorised the move so that Ms Cope

would not live on the same wing as her alleged victim. After her move, Ms Cope had a visit from her former partner in the community.

Segregation

38. The Head of Security and Operations was the adjudicator at Ms Cope's disciplinary hearing held later that afternoon. Ms Cope pleaded not guilty to the charge. The Head of Security adjourned the hearing because the police were investigating the allegation. She segregated Ms Cope under Prison Rule 45, which allows prison staff to segregate prisoners who are subject to police investigations into serious offences that occurred in prison custody and particularly those against another prisoner. She authorised that Ms Cope be segregated in her cell on B Wing, rather than in the segregation unit, because B Wing was a nicer environment and she did not think Ms Cope would benefit from the harsher environment of the segregation unit. She told us that she discussed Ms Cope's location with the deputy governor before reaching this decision.
39. PSI 64/2011 has a mandatory instruction that prisoners subject to ACCT procedures should be segregated only in exceptional circumstances. It says that the reasons must be clearly documented in the ACCT plan. The Head of Security wrote in Ms Cope's segregation history sheet, "Considered options of [Ms Cope] not being segregated however due serious nature of allegations [sic]". She told us that the allegations made against Ms Cope meant she might be a danger to any of the women in the prison, meaning that segregation was the only option available. She did not record or identify in the ACCT document any exceptional circumstances for Ms Cope's segregation.
40. A nurse assessed whether there were healthcare reasons not to segregate Ms Cope. One of the questions on the assessment asks, 'Do you think the prisoner's mental health will deteriorate significantly if segregated?', to which he answered 'no'. Another question asks, 'Do you think the prisoner will be able to 'cope' with a period of segregation?', to which he answered 'yes'. It is not clear whether the nurse considered Ms Cope's mental health history or her recent self-harm and food refusal when answering these questions. He concluded that there were no healthcare reasons not to segregate Ms Cope.
41. A SO held an ACCT case review with two B Wing officers after Ms Cope was segregated. There was no healthcare representative at the review. The SO recorded that Ms Cope seemed more positive than that morning. She told us that Ms Cope wanted to settle into her new cell and was looking forward to playing her keyboard. When she asked Ms Cope if she wanted to kill herself, she replied, "Don't know". She did not change Ms Cope's assessed level of risk or required observations.
42. On the morning of 20 November, Ms Cope told an officer that she would kill herself if found guilty. She said she planned to do this by not eating and drinking. Ms Cope did not eat her lunch or evening meal that day. (It is not recorded whether she ate breakfast.)
43. A SO led an ACCT case review that afternoon with an officer. No healthcare representative attended. The SO recorded that she had a long discussion with Ms Cope about various issues, including the allegation made against her, contact

from her son and moving wings. Ms Cope said she had not eaten, but had no plan to kill herself. She thought that Ms Cope did not eat because this was something she could control at a time when there were other things happening that were outside of her control. (The Head of Security and Operations told us that she and an officer held a similar view.) The SO set two new caremap actions: for Ms Cope to play her keyboard as a distraction technique from her issues, and for the SO to contact Ms Cope's sister to obtain her son's address to help Ms Cope contact him. She recorded that she left a message on Ms Cope's sister's phone that afternoon. She did not change Ms Cope's assessed level of risk but reduced the required observations to a minimum of three per hour. She told us that this was because Ms Cope said she had no intention of harming herself and not eating was not an immediate risk or justified the higher level of observations.

44. On the morning of 21 November, a nurse saw Ms Cope as part of a daily healthcare segregation round. She recorded that Ms Cope said she would kill herself if found guilty of the allegation made against her.
45. That day, prison staff began a food refusal log, and recorded that Ms Cope had some milk at breakfast but otherwise refused all meals.
46. That afternoon, the Head of Residence chaired a segregation review board, which should be held within 72 hours of first segregation and then at least at 14-day intervals afterwards, with the aim of returning the prisoner to standard prison accommodation. A custodial manager was also present. There was no healthcare representative, despite this being a mandatory requirement of Prison Service Order (PSO) 1700. No one completed a segregation health screen.
47. The Head of Residence recorded that Ms Cope appeared okay but said she felt fed up and had refused meals. She recorded that healthcare staff had raised no issues and said she thought she had spoken to a member of healthcare staff about this, but could not remember to whom. The record of the review does not note whether staff considered whether there were exceptional circumstances to justify Ms Cope's continued segregation, which is a requirement for a prisoner subject to ACCT monitoring. The Head of Residence told us that her understanding was that this was only required when a woman was held in a segregation unit, rather than segregated on a wing. She authorised Ms Cope's continuing segregation until 25 November, as the police investigation was ongoing.
48. The Head of Residence and a custodial manager held an ACCT case review immediately afterwards. The custodial manager recorded that Ms Cope was very subdued, had spent most of the day in bed, had not eaten and said she would stop drinking the following day. Ms Cope said she was frustrated that the investigation was not complete and felt she had lost everything. They recorded that staff should ensure they had two quality conversations with Ms Cope each day and recorded them in the ACCT document.
49. On 22 November, Ms Cope collected a breakfast tea pack, although there is no record that she ate or drank anything. She declined lunch. A nurse assessed Ms Cope in the afternoon. Ms Cope said she was fed up with the allegations made against her and did not want to live anymore. The nurse took clinical

observations, weighed Ms Cope, booked a follow-up appointment to review her food refusal and referred Ms Cope to the mental health team. Ms Cope ate a sandwich in the evening.

50. On the same day, Ms Cope's former partner in the community telephoned Foston Hall and said he no longer wished to receive mail or telephone calls from her.

23 November 2016

51. An offender supervisor explained Ms Cope's former partner's decision to her on the morning of 23 November. She recorded that the news hit Ms Cope hard and she said she could see no reason to go on. Ms Cope said she would no longer eat or drink and that she "has a plan and will follow this through". The offender supervisor told us that Ms Cope would not expand on this statement and, while her experience of Ms Cope was that she would sometimes say things to get a reaction, she was concerned about what might happen and thought Ms Cope's risk of harming herself had increased. She recorded her conversation in the ACCT document and the B Wing observation book.
52. Later that morning, a SO and an officer held an ACCT case review. The SO said she discussed Ms Cope's comment that she had a plan to end her life, and that Ms Cope said she felt as low as she ever had. She told us that, as the conversation developed, she thought that Ms Cope felt "silly" because her former partner was now in a relationship with a prisoner to whom she had introduced him. She advised Ms Cope to focus on the friends and family she had and that her son wanted to regain contact with her. Ms Cope had not yet spoken to her son, so the SO said she would contact him and try to facilitate this. (The SO left a message on Ms Cope's son's telephone after the ACCT case review.) She did not change Ms Cope's assessed level of risk or required observations.
53. After the ACCT case review, the SO spoke to a custodial manager about Ms Cope's segregation. She said she did not think that segregating Ms Cope achieved anything and that there were women on B Wing who would help to support her if she was allowed a normal regime. She asked the custodial manager to consider this at Ms Cope's next segregation review board. The custodial manager said that she told the SO that she did not have the authority to end Ms Cope's segregation that day and she should speak to the duty governor.
54. Ms Cope had a sandwich for lunch and spent some time reading on her bed. At 2.30pm, an officer completed an ACCT observation and recorded that Ms Cope acknowledged her when she asked if she was okay.
55. At around 2.50pm, the officer completed an ACCT observation. She noted that Ms Cope was walking into the bathroom. She told us that something made her feel uneasy and she therefore returned to Ms Cope's cell at 2.54pm. The officer went into the cell, knocked on the bathroom door and shouted to Ms Cope, but received no response. She said she then saw a piece of material at the top of the door, which she thought was a ligature, and radioed for medical assistance. She tried to open the door but was initially unable to do so as Ms Cope had wedged it shut. The officer managed to open the door and found Ms Cope lying on the floor with a ligature, made from clothing, around her neck. She removed the ligature and, at 2.56pm, an officer radioed a medical emergency code blue,

indicating a life-threatening situation. The control room operator called an ambulance.

56. An officer and a SO began cardiopulmonary resuscitation. A nurse attached a defibrillator, which found no shockable heart rhythm. The staff continued chest compressions until paramedics arrived at 3.12pm. At around 3.50pm, the paramedics took Ms Cope to the intensive care unit at the hospital. Ms Cope died at around 2.15pm on 29 November.
57. Prison staff found a note in Ms Cope's cell in which she wrote that she could not take any more and could not go on. In the note, Ms Cope had drawn a plan of how she intended to hang herself.

Contact with Ms Cope's family

58. A custodial manager telephoned Ms Cope's sister, her nominated next of kin, at around 6.00pm on 23 November, and informed her that Ms Cope had been admitted to hospital. The prison arranged for a taxi to take her to hospital to visit Ms Cope. The manager also informed Ms Cope's son. Ms Cope's sister was present when Ms Cope died. In line with Prison Service instructions, Foston Hall contributed to the costs of Ms Cope's funeral.

Support for prisoners and staff

59. The acting Governor debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.
60. The prison posted notices informing other prisoners of Ms Cope's death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Cope's death.

Post-mortem report

61. A post-mortem examination established the cause of death as hypoxic brain injury due to hanging.

Findings

Management of Ms Cope's risk of suicide and self-harm

62. Prison staff appropriately began ACCT procedures when Ms Cope harmed herself on 19 November. While it is clear from our interviews that most staff responsible for her care knew Ms Cope relatively well and understood the reasons for her distress, we are concerned that the ACCT procedures were poorly managed. While this might not have affected the eventual outcome for Ms Cope, it would have given prison managers and staff a better chance of producing a co-ordinated and effective care plan, aimed at addressing her issues and reducing her risk.
63. Prison Service Instruction (PSI) 64/2011 contains guidance and mandatory instructions on managing prisoners at risk of suicide and self-harm. It requires ACCT case reviews to be multidisciplinary where possible and says that, for the first case review, a healthcare representative must attend. There was no healthcare representative at any of Ms Cope's case reviews and no evidence that healthcare staff were consulted for their input. This is concerning, particularly given Ms Cope's mental health issues and food refusal.
64. A caremap must be completed at the first case review for all prisoners subject to ACCT monitoring. PSI 64/2011 says that the caremap should reflect the prisoner's needs, the triggers of their distress, and must aim to address the issues identified at the assessment interview. The caremap should set time bounded actions and be aimed at reducing the risk the prisoner presents to themselves. Some aspects of Ms Cope's caremap – such as assisting her (albeit unsuccessfully) to contact her family – were positive. However, there was no effective plan to support Ms Cope through the more significant aspects of her distress – the allegation made against her and her subsequent segregation.
65. While prison staff recognised that Ms Cope was not eating, they largely took this to be Ms Cope's way of coping with her distress by retaining control over something. While we recognise that PSI 64/2011 highlights that food refusal is not considered by law to be a form of self-harm, it also instructs that every effort must be made to find out why the prisoner is refusing food and the reasons for their refusal. We are not satisfied that these reasons were properly addressed through the ACCT plan and caremap.
66. PSI 64/2011 requires that prisoners assessed as at risk of suicide and self-harm should be segregated only in exceptional circumstances and that the reasons must be clearly documented in the ACCT record and include other options that were considered but discounted. Ms Cope was segregated on the same day that her ACCT was opened. There was nothing in her ACCT document to indicate that staff recognised that her segregation was exceptional, that any other options were considered, or that these exceptional reasons were reconsidered at any stage.
67. The custodial manager told us that the nature of the allegations against Ms Cope meant she might be a danger to any of the women in the prison, meaning that segregation was the only option available. While prison rules allow the segregation of prisoners when they are subject to police investigations into

serious offences that occurred in prison, we are not satisfied that these circumstances were so exceptional as to justify the segregation of a vulnerable woman, at risk of suicide and self-harm, for an indeterminate period. As noted, there was no evidence that any other options were considered.

68. On the morning of her death, Ms Cope told an offender supervisor that she had no reason to go on and she had a plan to end her life that she intended to follow through. A SO discussed these comments at the ACCT case review that followed. She recorded that Ms Cope said she was as low as she had ever been but, as the review progressed, told us she concluded that Ms Cope mainly felt “silly” about her relationship issues. The SO did not therefore consider that Ms Cope’s risk of suicide and self-harm had increased. The offender supervisor had known Ms Cope throughout her 18 months in prison and told us that she was concerned by Ms Cope’s statement. Although she made a record of her meeting in the ACCT document (and elsewhere), given the nature of her conversation with, and greater knowledge of, Ms Cope, she should have been invited to – or, at least, consulted before – the case review, in line with the multidisciplinary requirements of ACCT.
69. Guidance in the ACCT document is that risk is high when a prisoner has frequent suicidal ideas that are not easily dismissed, there is a specific plan with likely access to lethal methods and the situation experienced causes unbearable pain. Ms Cope had other risk factors for suicide and self-harm, including a history of harming herself, mental health issues, and she was segregated in prison. Her segregation meant that Ms Cope did not have the opportunity to speak to her friends and peers about the news she had received on 23 November. We consider that staff should have assessed Ms Cope’s risk of suicide and self-harm as high on the morning of her death, and increased the frequency of her observations in line with this.
70. In a PPO Learning Lessons Bulletin, published in March 2017, about self-inflicted deaths among female prisoners, we found that prisons should implement the ACCT process effectively as intended by PSI 64/2011. We found that this should include involving relevant professionals from different disciplines, setting appropriate caremap actions for reducing risk, and identifying risk levels based on established risk factors and triggers. In a PPO Learning Lessons Bulletin, about segregation, published in June 2015, we found that exceptional circumstances to justify the segregation of a prisoner subject to ACCT procedures should actually be exceptional, all other options should have been exhausted, and the reasons for the exceptional circumstances clearly documented.
71. In our investigations into the deaths of women at Foston Hall in July and September 2015, we also found that ACCT case reviews were not always multidisciplinary and, in the latter investigation, that prison staff underestimated the woman’s risk of suicide and self-harm. Our investigation into the death of a woman who died two weeks before Ms Cope found that ACCT case reviews were not always multidisciplinary, and that staff did not record the exceptional circumstances for segregating her when she was subject to ACCT monitoring. We make the following recommendation:

The Governor should ensure that staff manage prisoners at risk of suicide and self-harm in line with national guidelines, including that:

- **ACCT case reviews are multidisciplinary where possible and include all relevant people involved in the prisoner's care, with healthcare staff attending all first case reviews.**
- **ACCT caremap actions are specific and meaningful, and identify all of the issues identified at assessment interviews and case reviews.**
- **Prisoners at risk are not held in segregation unless all other options have been considered and excluded and there are fully documented reasons to explain the exceptional circumstances.**
- **Case reviews consider all relevant information that affects risk, and staff review the risk of suicide and self-harm whenever an event occurs which indicates an increase in risk.**

Ms Cope's segregation

72. PSO 1700 requires that an initial segregation review board must be held within 72 hours of a prisoner being placed in segregation. It states that the frequency of future boards should be decided locally, but should be at least every two weeks. Segregation review boards should consist of, among others, a chairperson, segregation officer and, where relevant, the ACCT case manager. It is a mandatory requirement that a healthcare representative attends. PSO 1700 says that the board should ensure there are exceptional circumstances to segregate a prisoner being managed under ACCT procedures, and that particular care should be given to authorising the continued segregation of a prisoner subject to ACCT monitoring.
73. Ms Cope's segregation review board took place on 21 November. No one assessed whether there were health reasons not to continue her segregation and there was no healthcare representative at the review board which, as well as being a mandatory requirement, is particularly important when a prisoner is at risk of suicide and self-harm and subject to ACCT procedures. The ACCT case manager was also not present at the review board.
74. The Head of Residence, who chaired the review, did not consider or record whether there were continuing exceptional circumstances to justify Ms Cope's segregation while subject to ACCT procedures. She told us that her understanding was that this was only required when a prisoner was segregated in the segregation unit, rather than on a standard residential unit. PSO 1700 makes no distinction between different locations of segregation. It is worrying that a fundamental safeguard for prisoners at risk of suicide and self-harm was not completed.
75. PSO 1700 requires that prisoners placed in segregation while subject to ACCT procedures must have a mental health assessment within 24 hours of their initial segregation. Despite these instructions, Ms Cope did not have a mental health assessment, and no one made a referral until 22 November.

76. In our PPO Learning Lessons Bulletin about segregation, we found that, when there are exceptional reasons to justify a prisoner at risk of suicide and self-harm being segregated, the additional required safeguards of PSO 1700 should be followed, including holding a mental health assessment within 24 hours. We also found that staff should consider a prisoner's fitness for segregation at segregation review boards and base decisions on the prisoner's full mental health history and other relevant factors that could potentially compromise their ability to cope. We make the following recommendation:

The Governor and Head of Healthcare should ensure that staff manage prisoners held in segregation in line with national guidelines, including that:

- **Segregation review boards include a healthcare representative and, when a prisoner is identified as at risk of suicide and self-harm, include the ACCT case manager. They should consider and record whether there are exceptional reasons to authorise continuing segregation.**
- **A segregation health screen is held before a segregation review board.**
- **Prisoners identified as at risk of suicide and self-harm should have a mental health assessment within 24 hours of their initial segregation.**

Emergency response

77. PSI 03/2013, on Medical Emergency Response Codes, sets out the actions staff should take in a medical emergency. It contains mandatory instructions for governors and directors to have a protocol to provide guidance on efficiently communicating the nature of a medical emergency, ensuring staff take the relevant equipment to the incident and that there are no delays in calling an ambulance. It stipulates that if an emergency code is called over the radio, an ambulance must be called immediately. Staff should ensure there are no delays in calling an ambulance and that it should not be a requirement for a member of the healthcare team or a manager to attend the scene before calling an ambulance.
78. Foston Hall's safety strategy instructs the use of the emergency codes 'red' and 'blue' to comply with PSI 03/2013. Examples of the circumstances in which staff should use code blue are when the prisoner has difficulty breathing or is unconscious, for instance, after a hanging. The safety strategy says that staff should, where appropriate, ask for emergency medical help using code blue when they discover a suicide attempt.
79. The officer did not radio a code blue medical emergency as she said she was unsure what was happening and her priority was to open the bathroom door. However, she told us that she knew the piece of material she had seen was a ligature and, at the same time, Ms Cope had blocked access to her bathroom and staff had assessed her as at raised risk of suicide and self-harm. While much of her actions were commendable – particularly the speed with which she entered Ms Cope's cell when she became concerned for her welfare – it would

have been appropriate to radio an emergency code when she identified that Ms Cope had tied a ligature. This would have alerted staff throughout the prison, including the emergency response nurse, and signalled the control room to call an ambulance immediately. We make the following recommendation:

The Governor should ensure that all prison staff are made aware of and understand their responsibilities during medical emergencies, including that they use the appropriate emergency medical code to communicate the nature of the emergency effectively.

**Prisons &
Probation**

Ombudsman

Independent Investigations