

**Investigation into the circumstances surrounding the  
death of a woman at HMP Foston Hall  
in January 2009**

**Report by the Prisons and Probation Ombudsman  
for England and Wales**

**July 2010**

This is the report of an investigation into the death of a woman, a life sentence prisoner, at HMP Foston Hall. The woman died on 30 January 2009, having been discovered hanging in her cell. I offer my sincere condolences to the woman's family and all those affected by her loss. I must also apologise for the significant delay in issuing this report and any additional distress that this has caused the woman's family and friends.

The woman had been in prison for over 12 years at the time of her death. She was working to address problems relevant to her offending with the aim of being approved for open conditions and eventual release on licence. She had transferred to Foston Hall in May 2008 to complete outstanding parts of her sentence plan. She was not considered a risk of suicide by staff or prisoners and her death came as a shock to all those who knew her.

The investigation was initially carried out by an investigator from my office (Investigator A) who was assisted by a call-off contractor. However, following Investigator A's retirement, the investigation was completed by another investigator (Investigator B). In addition, an independent review of the woman's medical care in custody was carried out by two doctors from Derbyshire County Primary Care Trust. I am most grateful to the Clinical reviewers for their assistance.

I would also like to thank the Governor and staff of Foston Hall for their full and ready co-operation during the course of the investigation. I am especially obliged to the Governor who is head of performance delivery, for her help in liaising with my investigators, particularly given the protracted time this investigation has taken.

Since the draft report was issued, I have become Acting Prisons and Probation Ombudsman. I endorse the nine recommendations made within this report. They centre on the handling and recording of the relationship the woman appears to have formed with another prisoner. I also consider whether staff action was appropriate following the woman's disclosure that this other prisoner had been violent towards her. Further recommendations focus on the initial request for medical assistance and an ambulance, ensuring prisoners' next of kin details are up to date, and training in resuscitation techniques.

It is clear that staff showed a great deal of interest in the woman and tried to assist her progress through the prison system to open conditions. The family liaison appears to have been of an excellent standard: both sensitive and providing information as necessary. I am pleased to observe that this continued for several months after the woman's death, including on the anniversary of her death earlier this year.

**Jane Webb**  
**Acting Prisons and Probation Ombudsman**

**July 2010**

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## SUMMARY

The woman was sentenced to life imprisonment in 1997 when she was 20 years old. This was her first conviction and therefore also her first time in prison. Over the following 11 years, she spent time in various prisons and made much progress in addressing the issues identified as related to her offending. This included spending 18 months in a therapeutic community at HMP Send. The end of therapy report indicates how positively she engaged while at Send.

In May 2008, she returned to HMP Foston Hall, having already spent time there earlier in her sentence. Her primary objective was to complete some psychological interventions and an accredited programme. This had been identified as necessary by the Parole Board to enable her to move to open conditions. The woman was again keen to complete this work but unfortunately, as is often the case, was hindered by a lack of resources and did not receive her first psychology appointment until January 2009. Whilst this was clearly a source of much frustration for her, she was kept informed of the likely delays and seemed relieved when she had her first appointment in mid-January.

While at Foston Hall, the woman developed a relationship with another prisoner. Both staff and prisoners commented that this was a very volatile relationship. In October 2008, she moved wings and employment at the prison, seemingly to have more time to herself. However, decisions such as the reasons behind her movement to another wing were not well documented, and more could have been done to challenge the relationship between the pair. I make recommendations to this end.

She also disclosed to a member of staff that the other prisoner was violent towards her. I have considered what action was taken as a result of this information and whether this was in line with Foston Hall's violence reduction policy. Around a week before she died the other prisoner was moved onto the same wing as her. In her police statement, the other prisoner admitted to being violent towards the woman the night before she died.

However, despite these matters, there was no indication that the woman was a risk of self-harm or suicide during her time at Foston Hall. Although a private person, staff considered her to be strong and she was popular amongst the other prisoners. It seems to have been a complete shock to all those who knew her when she was discovered hanging in her cell on 30 January 2009.

Sadly, concerted resuscitation efforts by prison and healthcare staff were unable to save the woman. Whilst staff followed Foston Hall's procedures correctly, it seems some minor amendments could be made to reduce the time taken to request an ambulance and for the emergency equipment to reach the cell. Consideration could also be given for basic first aid training for all staff.

Although there were some initial difficulties with the woman's next of kin details, staff made efforts to ascertain the correct details and the ongoing family liaison was of an excellent standard. The woman was remembered by staff and prisoners at the prison on the first anniversary of her death in January 2010.

## THE INVESTIGATION PROCESS

1. The investigation was opened on 5 February 2009 when Investigator A, issued notices announcing the investigation to staff and to prisoners. The notices included an invitation to those who wished to submit information related to the woman's death to make themselves known. A number of prisoners came forward and were subsequently interviewed. Investigator A met the Governor, Deputy Governor, and the chairs of the Independent Monitoring Board (IMB) and the local branch of the Prison Officers' Association.
2. Investigator A was given access to the woman's prison files, including her medical record. He later returned to Foston Hall with the off call contractor on 12, 13, 25 and 26 February to interview staff and prisoners.
3. An independent clinical review of the woman's health needs whilst she was in custody was carried out by the two clinical reviewers on behalf of Derbyshire County Primary Care Trust.
4. One of my family liaison officers telephoned the woman's husband on 2 March to advise him of the investigation and invite him to raise any matters he wished to be addressed. She also telephoned the guardians of the woman's son on the same day. My senior family liaison officer, visited the woman's husband on 6 April, along with the Investigator A. The woman's husband raised the following issues:
  - The reason for her move from A wing to B wing in October 2008 and how this affected her.
  - The delay in her receiving assistance from the psychology department.
  - If she gave away clothes around Christmas and if this was an early sign of her intentions.
  - Why her next of kin details had not been updated following his marriage to her.
5. I hope that this report helps the woman's family better understand what happened in the time leading to her death.
6. Investigator A retired before he could complete the investigation and it was passed to Investigator B, on 7 January 2010. Investigator B has had full access to the prison documentation and has received copies of the transcripts of all interviews. Additionally, she visited Foston Hall on 9 February where she met with the IMB and several members of staff.

## HMP FOSTON HALL

7. The Prison Service first acquired Foston Hall and the grounds in 1953. In 1996, it was closed for major refurbishment before being reopened on 31 July 1997 as a women's training prison. A remand centre was added in 2005 and a juvenile unit in 2007. It is now categorised as a prison and young offender institution. The prison has eight wings which accommodate up to 283 women, comprising 187 convicted prisoners, 80 remand prisoners and 16 juvenile prisoners.
8. The prison has a healthcare centre with three sites: for remand prisoners, sentenced prisoners and juveniles. There is 24 hour nursing cover and Derby Medical Service (now known as Derbyshire Health United) provides doctor cover. There is an inpatient facility in the sentenced area with three beds. These are largely reserved for prisoners with mental health problems.
9. Foston Hall was most recently inspected by the HM Chief Inspector of Prisons, between 28 September and 2 October 2009. However her report has not yet been published, I refer here to a previous report following an unannounced follow up visit by the Inspectorate in May 2007. In this report, the HM Chief Inspector of Prisons said that Foston Hall was still coming to terms with its new function as a remand prison. Self-harm, suicide and induction procedures were not sufficiently robust to deal with the more vulnerable remand population, but Foston Hall "remained overall a reasonably safe place".
10. The HM Chief Inspector of Prisons also found that convicted prisoners continued to have plenty of time out of cell, with good levels of activity and access to education and work that allowed them to acquire skills and qualifications. She believed that Foston Hall provided these prisoners with a good resettlement strategy. Prisoners said they were well supported by staff and Listeners, including in the period after the previous self-inflicted death in 2007. With regard to staff-prisoner relationships, all the prisoners with whom the Inspectorate spoke individually or in groups said they had at least one member of staff they could rely on and that most, but not all, staff were helpful.
11. An Independent Monitoring Board (IMB) is appointed to each prison by the Secretary of State for Justice. Its members are wholly independent of the National Offender Management Service (NOMS) and the prison's management team. Each IMB is required to produce an annual report to the Secretary of State, highlighting good practice and areas of concern.
12. Foston Hall's latest IMB report covers the period December 2007 to November 2008. The Board believed that the ethos in Foston Hall created a "friendly and sociable environment, to which the majority of prisoners make a very positive contribution." Prisoners were able to discuss problems with members of staff and sought solutions in recognised ways.

13. The Board also reported that, although there was minor trading in drugs, staff were alert to the situation. There was no serious presence of illegal substances in the three areas of the prison, and many prisoners co-operated with staff in order to prevent this. They regarded this as being evidence of the effective drug strategy operating in Foston Hall.
14. NOMS is responsible for the management of prisons in England and Wales. Every three months it publishes an assessment of each prison's performance against 34 measures. Prisons can gain a rating of between one (serious concerns) and four (exceptional performance). Foston Hall has scored three (good performance) three times and four once in the last year.
15. The woman's death was the fourth to have occurred at Foston Hall since April 2004 when I began investigating all deaths in prisons in England and Wales. She was the second prisoner to die apparently at her own hand. The only similarity I have identified between these two deaths was that both women were in difficult, close relationships.

## KEY FINDINGS

### June 1996 – May 2008

16. The woman was convicted of murder on 16 April 1997 at a local Criminal Court and sentenced to life imprisonment. She had been in HMP Holloway on remand since June 1996, and remained there after conviction until July 1997. She then spent time at various prisons including HMP Bullwood Hall, HMP Foston Hall, HMP Send and HMP Cookham Wood.
17. During this time, staff completed four self-harm at risk forms (F2052SH) on her. The brief details of these were as follows. On 5 September 1996, while at HMP Holloway, she indicated she would self-harm if sentenced to life imprisonment. On 4 June and 7 October 1999, whilst at Bullwood Hall, she was observed to be very low in mood and took an overdose of medication on one occasion. The most recent at risk form was completed on 29 March 2000, when she said she had been finding prison difficult since she had taken an overdose. There had been no concerns regarding suicide or self-harm since that time.
18. With regard to medical treatment, the woman had a long history of acne which had been treated both with topical (rub-on) treatments and oral antibiotics. She had a cyst removed from her left breast in 2002 and her wisdom teeth removed in 2003.
19. She returned to Foston Hall from Cookham Wood in January 2003, and remained there until February 2005, during which time she married her husband in a ceremony at the prison.
20. In 2005, the woman transferred to Send to join the therapeutic community. Send is the only female prison to have a therapeutic community. It provides a long term, residential, offending behaviour intervention for prisoners who have a range of offending behaviour risk areas, including emotional and psychological needs. Prisoners are expected to stay for at least 18 months and the core day is structured around a therapy group. This is either a small group or a large community meeting. All decisions are made in a democratic way with voting by the whole community of prisoners.
21. The woman completed her therapy on 4 January 2007. The end of therapy report noted the considerable contribution to the group and positive progress she had made across all the issues covered including: offending behaviour, drug and alcohol misuse, anger, violence, fear, isolation, rejection, shame, self-esteem, problem solving, relationships, parenting experiences and her relationship with her son. The report concluded:

“She is a very bright woman with considerable abilities ... She has worked hard whilst she was in the Community and deserves a lot of credit for what she has achieved for herself.”

22. On 17 October 2007, the Parole Board rejected the woman's application to move to open conditions. They indicated that she needed further psychological assessments as well as completion of the cognitive skills booster accredited programme (a group programme that addresses problem solving skills).

### **Foston Hall, May 2008 to January 2009**

23. The woman returned to Foston Hall on 8 May 2008 to complete the psychological and programme aspects of her sentence plan. On the way she spent a night in healthcare at HMP Peterborough. The records do not indicate why this happened.
24. On reception at Foston Hall, she was assessed by a Nurse and the reception healthscreen indicates the Nurse had no concerns regarding the woman's risk of suicide or self-harm. She was located on A wing in a single cell.
25. The following day, the woman had an appointment with a Senior Officer (SO) from the offender management unit. The woman's only concern was about obtaining a psychology appointment so that she could complete this work and progress to open conditions. The SO therefore completed a referral via email to the psychology department the same day.
26. Numerous entries in the woman's wing history sheet throughout May and June note that she was a very helpful and co-operative prisoner who helped clean the wing without being asked. She was also working in the kitchens at this time.
27. A trainee forensic psychologist who has worked at Foston Hall since 2003. She told the investigators that, having received the SO's referral, on 9 July the psychology department completed an induction with the woman. This resulted in a referral to the trainee forensic psychologist for her to assess whether the woman needed more one to one reviews. Unfortunately, there was a long waiting list for appointments with the psychology department at this time.
28. As a life sentenced prisoner, she should have had a personal officer located on her wing. (The personal officer is a prisoner's first point of contact for day to day issues and also a source of support.) However, it is unclear whether she had a personal officer immediately. She also had an offender manager and a lifer manager who were responsible for ensuring there was an up to date sentence plan which was followed, and that regular assessments and reports were completed on time. (The aim of a sentence plan is to enable a prisoner to use their time constructively and to avoid further offending on release.)
29. An Officer introduced herself to the woman as her lifer manager on 11 July. In interview, she said the woman was angry as she had still not received a psychology appointment and believed she was being "looked over". The

Officer advised her she would be able to discuss this at her sentence board in a few days.

30. On 20 July, an Officer introduced himself as the woman's personal officer. Again, she told him of her frustration regarding the lack of progress in obtaining a psychology appointment. It is not clear from the documentation or from speaking to staff whether she had a personal officer before this time. However, the investigator spoke to the Governor who was head of residence at the time. He was certain she would have been allocated a personal officer as soon as she was located on the wing. He said that since the woman's death the prison had now moved to a computerised system (called P-NOMIS) and the information would be recorded there in future.
31. A prisoner had been located on A wing at Foston Hall since December 2007. When the woman transferred to Foston Hall, they became friends. From the police statement given by her and the investigators' interviews with prisoners and staff, it is apparent that her relationship with the woman became a more involved one over time.
32. In Prisoner A's police statement she does not indicate exactly when she formed a relationship with the woman, but the information from staff and prisoners suggests some time in July 2008. Prisoner A described their relationship as very good for the first few months but they then started to "bicker" a lot which caused them problems with prison staff. She declined to be interviewed by the Ombudsman's investigators.
33. SO A, who worked on A wing, said she knew that the woman and Prisoner A were in a relationship. She recognised that there were some difficulties in their relationship but the woman seemed to be coping and was quite an assertive, independent prisoner who did not cause the staff any problems. She believed that the woman was a source of support for Prisoner A. SO A had heard a few "heated rows" between the pair when they were both on A wing but nothing "major", although staff realised there was a problem in their relationship. It was normal for them to fall out or break up and then get back together quickly.
34. All the prisoners the investigators spoke to described some level of difficulty in the woman's relationship with Prisoner A. A lot of prisoners said that the woman would try and appear strong but was a very private person who would not share her problems. Others described her as being controlled by Prisoner A, such that she felt she was "walking on eggshells" and was constantly wary of upsetting Prisoner A. Some prisoners said she looked scared and intimidated by Prisoner A.
35. A number of prisoners told the investigators that either the woman or Prisoner A had told them that Prisoner A was violent towards the woman. Some said they heard Prisoner A shouting at her and punching walls, while others saw suspicious marks on the woman's neck and arms. She had confided to some prisoners that they were caused by Prisoner A's violence towards her, but she

did not want prisoners to tell staff about this and staff therefore remained unaware.

36. A member of the garden staff, (Staff A) first met the woman in August 2008 when, at her own request, she transferred to working in the gardens. Prisoner A was already working in the gardens. Staff A quickly became aware that the woman and Prisoner A were in a relationship by their general demeanour when walking to and from work together.
37. Entries during August by the woman's personal officer, noted that she seemed more settled but was still waiting for an appointment with the psychology department. The personal officer also recorded that the woman's moods were quite changeable; sometimes she appeared happy and at other times became very quiet and non-communicative with staff. It is also apparent that she was becoming increasingly frustrated at not receiving a psychology appointment and was concerned how this would affect her chances of being considered for open conditions.
38. On 28 August, Nurse A reviewed the woman's existing medication for acne. The woman was referred to the doctor, whom she saw a few days later. A Doctor prescribed Dianette (a tablet) and Zineryt (a cream) for her acne.
39. From around the end of August, Staff A noticed tension between Prisoner A and the woman. The pair frequently argued, with Prisoner A being the more vocal. Staff A became uneasy about this relationship and considered what would be the most appropriate action, including stopping one of them from working in the gardens. However, this did not occur until some time later.
40. It is recorded in the offender management unit record that the woman was told in September that she would not receive a psychology appointment until January 2009. She was upset about this and asked to be moved to another prison.
41. On 9 September, Officer A introduced herself as the woman's new personal officer and discussed her sentence plan targets with her. The officer noted that she was happy on A wing and had no concerns. In interview, Officer A said she was personal officer to around seven prisoners. She explained that officers received some dedicated personal officer time but not as much as she thought they needed.
42. Officer B works on the integrated drug treatment strategy within Counselling, Assessment, Referral and Throughcare (CARAT), the prison substance misuse service. She completed one to one sessions over a number of months with the woman. Officer B believed the woman to be a very motivated individual, determined not to misuse drugs on release.
43. In interview, Officer B said that at one appointment in September the woman was very upset and crying, markedly different to how she had been in previous sessions. The officer noticed she had lost a lot of weight. She told Officer B that her relationship with Prisoner A was not working out and

Prisoner A had been violent towards her by hitting her, holding her hands around her throat and spitting at her. The woman thought she was “going backwards” and replicating some of the relationships she had been involved in before coming into prison. She believed she had to end the relationship as it was not good for her “physically, mentally or emotionally” and she felt drained. Officer B and the woman discussed her prospects and whether she could change jobs or wings. She trusted Staff A. The officer therefore agreed to speak to Staff A and the woman told Officer B she would end the relationship.

44. She also told Officer B that other issues were upsetting her such as the lack of contact from the psychology department, and she was worrying about her future application for parole. The officer had considered opening an Assessment, Care in Custody and Teamwork (ACCT) plan at that time, and spoke to Officer A about this and the volatile nature of the woman’s relationship. (The ACCT procedure – which replaced the F2052SH – provides additional monitoring and personalised support for prisoners considered to be at risk of self-harm and suicide.) Both decided that opening an ACCT was not necessary at present since they did not assess her to be a risk to herself. Instead, they agreed that Officer A would monitor her more closely. She would record their conversations in the wing history sheet as she had also been discussing the situation with senior officers. This information was not recorded in the woman’s wing history sheet and the investigators have not had access to the wing observation book for this period as it appears to have been mislaid within the prison. Nor does anyone seem to have further discussed these disclosures of violence with the woman.
45. After her meeting with the woman, Officer B called Staff A and asked if they could separate the woman and Prisoner A at work. Staff A told the officer that she had already become concerned about the changes in the woman as she had become very withdrawn recently. In any case, Staff A had been considering moving her to the sanctuary as a result of the change in her behaviour. (The sanctuary is an area of the prison where various animals and birds are kept. Looking after the animals here is considered one of the most trusted positions in the prison.)
46. In mid-September, Staff A said the woman and Prisoner A had another, more volatile argument, and she and the garden manager told them that their behaviour was completely unacceptable and staff were not happy with them working in the gardens together. Staff A received a message from Officer A later in the morning to say that the woman and Prisoner A had been volatile on the wing. Staff A therefore went to speak to Officer A, and the two of them subsequently discussed the situation with the Governor who was head of residence, as well as with both prisoners’ lifer managers.
47. Staff A remembers recording this in the observation book, although, as noted above, the investigators have not been able to gain access to this. The Governor who was head of residence told Officer A and Staff A that the two prisoners could be separated at work if necessary. In interview, Staff A said that if prisoners behave badly they could also consider issuing a warning

under the Incentives and Earned Privileges (IEP) Scheme. (IEP rewards and encourages prisoners' good behaviour and has three levels – basic, standard and enhanced. Enhanced is the highest of the three.) However, Staff A did not believe this was necessary for either the woman or Prisoner A at that time, and they continued to work together.

48. The woman told Officer A she was feeling quite stressed about a number of issues on 17 September. She was concerned about her acne and wanted treatment. She was also concerned that she had not yet started the cognitive booster programme or received a psychology appointment. Furthermore, she was not sleeping well at night when officers were checking on other prisoners thought to be at risk of self-harm. Officer A assured her that she would look into all these issues and get back to her.
49. Doctor A assessed the woman later that day. She was upset due to the severity of her acne. She had tried many different treatments in the past and had not yet started on the Dianette she had been prescribed. It is not clear from the medical notes why she had not yet started this treatment. Doctor A made a referral to the Dermatology Department at Derbyshire Royal Infirmary with a view to consideration of prescribing Roaccutane (capsules for the treatment of acne which contain the ingredient isotretinoin). The referral letter stated that “the condition has caused a definite deterioration in her mental state”.
50. A few days later, Officer B went to visit the woman who she judged was much improved in her mood, with better eye contact and open body language. Officer B then continued to see her about once every three weeks until 23 December. She then closed her file as she believed the woman had completed all the relevant work she could. The woman did not give her any further reason to be concerned.
51. The woman gained a place on the cognitive booster programme in October. However, she told Officer C that she did not want to go on the course because Prisoner A would also be on it and she did not want to discuss the personal issues in her life within a group context and in the presence of Prisoner A. The officer was aware that Prisoner A and the woman were in a difficult relationship.
52. In her interview, a prisoner and friend of the woman, (Prisoner B) was not sure about exact timings but estimated that it was around October 2008 when she saw a bruise extending from the woman's armpit to her elbow. When Prisoner B asked about it, the woman said she had done it in the gym. She also saw red marks on the woman's neck which she said she had hurt on the door. Prisoner B did not tell staff about the injuries she had noticed on the woman.

53. On 6 October, the woman told Officer C she was concerned she had not started any work with probation. Officer C contacted the seconded probation officer, who arranged an appointment for 22 October.
54. In her police statement, Prisoner A said that, due to their constant arguing, Officer A had a meeting with her and the woman. Officer A told them both that their behaviour was affecting the wing and they needed to do something about it. Prisoner A says that she had a long talk with the woman. They agreed to keep their relationship a secret from then on and the woman would ask to move to B wing.
55. Staff A remained concerned about Prisoner A and the woman arguing at work and the effect it was having on the woman. Since Staff A believed it would be unfair to single one of them out and remove them from the gardens, she spoke to the head of activities. She then had a meeting with Officer C and the woman on 15 October. The woman said she wanted to distance herself from Prisoner A, so Staff A asked her if she would like to move to the sanctuary. The woman did not think that this would be fair on Prisoner A who had wanted to work on the sanctuary before her. Officer C said she would deal with Prisoner A, and the woman agreed to the move. The woman also said she had requested a move to B wing. Officer C agreed to chase this for her.
56. The following day, the woman went to see Officer C to say that she did not want to work in the sanctuary. Officer C presumed that this was so as not to upset Prisoner A.
57. The same day, the woman saw Nurse B on the wing and asked her if she could have some "time out" on healthcare as she was having some problems at the time. Nurse B told the woman that healthcare could not offer such a service and asked if she had told wing staff what was worrying her. The woman said she had. Nurse B told the wing staff about the woman's request and that her long term relationship had broken up, but they were unaware of any other issues. There is no note in the woman's file to indicate whether wing staff spoke to her about this request to find out what she was upset about.
58. Officer C advised the woman to submit an application to move from A to B wing since her mood was deteriorating. Although she had never discussed her relationship with Officer C, she was aware of its volatile nature. It is difficult to determine from the documentation who approved the woman's subsequent move to B wing and the exact reasons for it. There is no reference to it in the woman's wing file or in the A and B wing observation sheets to which the investigators have had access.
59. SO A thought Prisoner A and the woman had had a disagreement prior to the move. She believed that officers moved Prisoner A downstairs hoping that this would alleviate the problem, but the next day the woman moved to B wing. SO A was not involved in the decision but said in interview that staff were aware that the woman was moving to B wing to get some space from Prisoner A .

60. The investigators asked several prisoners about the woman's move from A to B wing. Those questioned said they believed she asked for the move to get away from Prisoner A, and that they split up at this time following an argument.
61. One prisoner, (Prisoner C) said that the woman had told her that she had had an argument with Prisoner A, who had broken up with her. As the woman still had feelings for her, she did not feel she could cope being on the same wing without being in a relationship with her. On 17 October, the woman was relocated on B wing.
62. Officer D was appointed as the woman's personal officer following her move to B wing. In interview, the officer said she is rarely scheduled time solely for personal officer duties, but made an effort to speak to all the prisoners for whom she is personal officer every weekend (about 12 prisoners in total). She explained that being a personal officer to a prisoner meant that she would try to get to know them better than others, and be their first point of contact for queries or issues. Officer D read through the woman's file before meeting her. This included information such as her wing history sheet and length of tariff. She also got lot of information from the woman herself.
63. As there was no information in the paperwork regarding the woman's relationship with Prisoner A, Officer D believed they were just good friends. In interview, Officer E, who also worked on B wing, said he too was unaware of why the woman was transferred to B wing and of her relationship with Prisoner A. He added that, after she moved wings, she spent much of her time associating on A wing anyway.
64. Officer D said when she moved to B wing they had a general discussion about the woman's son, previous prisons she had been to, and her interests. She spoke to the woman over the following two months regarding her sentence planning and what she needed to focus on.
65. Once she had moved to B wing, she also started working in the sanctuary. Officer B considered that this should have provided some space for the woman from Prisoner A since, as a gardener, Prisoner A was not allowed to go to the sanctuary. However, numerous prisoners said they later saw Prisoner A going to the sanctuary and arguing with the woman.
66. In Prisoner A's police statement, she said that following the move, her relationship with the woman improved, such that prison staff commented on how well they were both doing since being separated. If staff asked if they were still in a relationship, they would both always deny it.
67. SO A said that, following the move, the woman would go to A wing on a daily basis to see Prisoner A and the pair would not be seen without each other. SO A believed the relationship to have resumed. Prisoners interviewed also confirmed they thought this was the case.

68. A seconded probation officer who began working at Foston Hall in September 2008 splits his time between the offender management of prisoners serving life sentences and general probation enquiries. He manages around 20 of the 43 prisoners serving life sentences at Foston Hall.
69. At her first appointment with him on 22 October, the woman was mainly concerned about getting a psychology appointment to better her chances of moving to open conditions. He told her that there were some resource issues within the psychology department and a lot of programmes and appointments were being postponed to be scheduled in January 2009.
70. In interview the probation officer said that they discussed her relationship with prisoner A, which he understood had finished in September. The woman had told him that she was glad it was over as she did not feel it was a healthy relationship. She also told him that prisoner A was aggressive but did not say she was violent towards her. The woman told him she had resolved not to get involved in any more prison-based relationships.
71. From later sessions, the probation officer said that, as far as he was aware, the woman and prisoner A were not even talking to each other until mid-December. Both he and Officer C did one to one work with the woman, with the probation officer focussing on relationship issues. As the sessions progressed, the woman became more concerned about talking about her relationship with her husband rather than with prisoner A. He did not notice any change in her physical appearance or weight loss, but said he would have found this difficult to judge as she wore baggy clothing. He would regularly exchange information with her offender supervisor and personal officer.
72. In a meeting with Officer C on 5 November, the woman said she was happy, had no issues at that time, was enjoying working at the sanctuary, and would do the next cognitive skills booster course. A week later, she told Officer C she was becoming increasingly frustrated that she had still not received an appointment with the psychology department. She had been told there would be a delay in this until the New Year because of staff shortages.
73. The woman attended the dermatology outpatient clinic at Derbyshire Royal Infirmary on 21 November. She was assessed by Doctor B who suggested isotretinoin (Roaccutane) to treat her acne. She was also given information leaflets. Blood tests were arranged with an appointment for the following week. There was no record of any assessment of the woman's mental state.
74. One of the leaflets given to her advised that she should tell the doctor if she had any history of depression. It also explained that some side effects of the medication could be mood changes (depression or symptoms of mental disorders) and, in rare cases, suicide and attempts of suicide. The clinical reviewer notes that there was no particular emphasis on this advice in the leaflet and it is amongst a number of other pieces of information.
75. When the woman returned to Foston Hall from the hospital she was assessed by Nurse C who noted she needed fasting bloods before her follow up

appointment at the hospital in a week. This blood test was taken on 24 November. The following day, the woman had an appointment with a Healthcare Assistant (HCA). The HCA noted that the woman was concerned about starting to take prescription medication which advised she should not smoke whilst taking it. She asked for nicotine patches and a message was left for the smoking advisor.

76. The woman attended Derbyshire Royal Infirmary on 28 November. She was assessed by Doctor B who prescribed 30mg of isotretinoin daily to start on the second day of her menstrual cycle. There is no written record of any assessment of her mental state. The notes show that Doctor B discussed the case with the consultant dermatologist.
77. A member of staff from administration support for learning and skills (Staff B) said in interview that the woman was undertaking an Open University course which she had started at Send. In December, she told her that she had failed the course. Staff B took some time discussing this as she knew the woman lacked self-confidence and feared she would take the news badly. However, she was positive and made an application for further funding from the Prisoners' Education Trust.
78. The woman attended an appointment with a member of staff on 8 December to discuss stopping smoking. They agreed to hold one to one sessions in the future to assist with this.
79. On 18 December, the woman was relieved to be told that a psychology appointment had been scheduled for January 2009. Officer C had also put her on the list for the next cognitive skills booster course. Her next Parole Board hearing, due later in 2009, would determine if she could transfer to open conditions. If successful, she would then remain in open conditions for at least two years before potentially being released on licence.
80. The same day, the woman attended Derbyshire Royal Infirmary where she was assessed by a dermatology nurse (Nurse D). Nurse D noted that the woman was experiencing side effects of dry skin and lips but was coping well. She recorded that she had started taking the medication on 4 December. Nurse D gave the woman a further prescription for one month's medication and arranged for her to attend a review with the consultant in one month. Again, she was seen by Nurse C when she returned from the hospital who noted the details of the appointment.
81. The woman's husband has asked if she started giving away her clothes around Christmas time. None of the prisoners and staff interviewed for this investigation mention this.
82. On 27 December, a personal officer entry in the woman's wing history sheet by Officer D indicated that she continued to enjoy working in the sanctuary and had raised very few concerns on the wing. It was noted she had enjoyed her telephone conversation with her husband that day.

83. A fellow prisoner and friend of the woman's, said she saw cuts to the top of her legs in December that she admitted she had made herself. The woman asked her not to tell anyone and her friend did not want to betray this trust. The woman also confided in another prisoner (Prisoner D) that she had self-harmed around the end of December by scratching her legs with a razor.

### **January 2009**

84. The woman had an appointment with a stop smoking advisor, on 7 January. The woman she saw gave her advice about motivation and asked her to set a 'quit' date. Blood tests were also taken by a nurse on this day.
85. A member of staff from the psychology department (Staff C) had her first interview with the woman on 12 January. She was unaware that psychological sessions were one of the reasons for the woman's transfer to Foston Hall. This was the only time she met her and their session lasted around two hours. It was a general background session looking at the woman's school, family, relationships and offence, amongst other things. She came across as being quite positive, had done a lot of work and was keen to achieve the targets set for her. In interview, Staff C added that the woman did not voice any frustration about the delay it had taken to get an appointment.
86. The psychological assessment was to take place over three sessions and Staff C had therefore not come to any professional conclusion. She arranged a second interview for 27 January, but this did not take place as the woman forgot about it. It was re-booked for 3 February.
87. During a telephone conversation with her son's legal guardian the following day, the woman explained that she was relieved about the psychology session. She also spoke to her son.
88. Security intelligence reports (SIRs) were submitted in mid-January surrounding the trading of the prescription drug tramadol (a painkiller) between prisoners. (SIRs hold security information that has been collected on prisoners. Any member of staff can record information on a prisoner, no matter how small or insignificant it seems. The intelligence received is then evaluated on the reliability of the source and the potential impact on the prison's security should it be true.)
89. As a result of these SIRs, the Governor who was head of residence appointed Officer F to conduct a Violence or Anti-Social Behaviour Investigation. While this was happening, those believed to be involved were locked in their cells for up to two days at the request of the same Governor. This included Prisoner A. Officer G said in interview that the woman became quite upset when she was told she was unable to visit Prisoner A in the meantime.
90. The investigation concluded, among other things, that Prisoner A had been taking tramadol that had not been prescribed to her, by trading items with other prisoners. Prisoner A had admitted this to Officer F. The woman had been interviewed as part of this investigation since she was named as being

present when there was a verbal disagreement between Prisoner A and another prisoner regarding the trading. Officer F spent two hours interviewing the woman and she denied obtaining medication on behalf of Prisoner A.

91. The investigation concluded that Prisoner A was struggling with a number of issues and that consideration should be given to a move to B wing where she would have more support from her friends. This was on the understanding that she would start to focus more on offending behaviour work and other issues, and stay out of trouble. Officer F had understood from the woman that she was also keen to be moved as she was very concerned for Prisoner A, but she was unaware that the woman had previously moved from A wing. Her investigation was forwarded to the Governor who was head of residence.
92. A number of prisoners told my investigators that the woman was involved in getting tramadol for Prisoner A. Prisoners are entitled to buy 'canteen' on a weekly basis, including sweets, crisps, non-alcoholic drinks and tobacco. (Canteen is the term for the prison shop where prisoners can buy or order goods each week to a limited value.) Prisoners noticed that despite spending around £20 on items from the canteen, the woman would ask to borrow tobacco or coffee a couple of days later, although she was usually very self-sufficient. She told a number of prisoners that she was trying to clear debts Prisoner A had built up with other prisoners for tramadol, and therefore traded her canteen with them. Other prisoners described how every Wednesday she would bring a carrier bag of items to work for Prisoner A. Another prisoner (Prisoner E), said the woman increasingly "walked around in her own world", worrying about how to pay for the drugs. Prisoners said that she told them she hoped once the investigation had taken place the medication trading would stop. Prisoner A told police that, whilst she was aware medication trading took place at Foston Hall, neither she nor the woman had been involved.
93. The woman and Officer C had a one to one session on 20 January in which she seemed positive and glad that her psychology and programme appointments would soon start. She had also recently become a Buddhist and they made an application for her to have an escorted visit to a service at the local Buddhist centre.
94. On 21 January, the woman attended Derbyshire Royal Infirmary where a consultant dermatologist (Doctor C) assessed her. His notes state that the woman's acne had not shown any improvement after eight weeks on isotretinoin, and he therefore doubled her dose to 60mg daily, with a follow up appointment after four weeks.
95. When she returned to Foston Hall she had another review with the stop smoking advisor who noted she continued to smoke and had cited stress as a contributing factor. She told the clinical reviewer that the woman had appeared "cross" on this day and said she was upset about a friend of hers being transferred to another prison.

96. The woman telephoned her son later that evening. He was out so she spoke to one of his legal guardians.
97. The following day, she attended a health and safety course with a number of other prisoners. During the course another prisoner asked the tutor whether it was true that she “read auras”. The tutor confirmed this to be correct and proceeded to read the woman’s aura without her asking her to. The tutor told her that she was aggressive and that she would not want to meet her “down a dark alley”. The other prisoner said that the woman became visibly upset by this and told the tutor that she had not asked for her aura to be read. In interview, the prisoner said she knew the woman had discussed the effect of this on her with other prisoners, and she believed it had contributed to her low mood before she died.
98. A SIR was submitted when a prisoner gave this information after the woman’s death and the matter was investigated by Principal Officer A. The tutor was told her actions were unacceptable and she should not read prisoners’ auras, even if asked to do so.
99. Staff told my investigators that the woman began repeatedly asking for Prisoner A to be moved to B wing at the beginning of January 2009. The wing observation books for B wing from 21 October onwards make no reference to the woman apart from once on 16 January when it is noted that she made a request for Prisoner A to move to B wing.
100. The woman said she wanted Prisoner A to move wings as she was concerned for her welfare. Officer C was aware Prisoner A was having a difficult time, but told the woman that she did not think it was a good idea due to the previous problems. However, she assured her they were just friends now and she was only concerned for Prisoner A’s welfare. Officer C told my investigators that, although Prisoner A’s behaviour had deteriorated and she had lost an enhancement under the IEP scheme, she was not a problem on A wing and this was unconnected to her move. Officer C did not believe the woman and Prisoner A to be in a relationship at this time.
101. Officer C approached Senior Officer B about Prisoner A moving to B wing, and a cell had become available. Senior Officer B advised her to speak to the Governor who was head of residence and Senior Officer A who approved the move.
102. However, Senior Officer A said that initially Prisoner A’s request to move to B wing had been rejected. She told my investigators that prisoners are not permitted to change wings due to relationship issues, but should be moved for discipline reasons. Prisoner A persisted in wanting to move and spoke to Senior Officer B who referred the matter to Senior Officer A. Officer C also asked Senior Officer A if Prisoner A could move. Senior Officer A said that if anything it would need to be a ‘progressive move’ agreed by the residential Governor.

103. The woman asked Officer D to help get Prisoner A moved to B wing as she was worried that she would self-harm. Officer D had the impression that she was being “emotionally blackmailed” by Prisoner A. Despite her concerns, as she was unaware of the relationship between Prisoner A and the woman, she was supportive of the move and told Officer C. Once Prisoner A moved the woman seemed relieved, but she never discussed Prisoner A’s presence with Officer D.
104. On the morning of the 23 January, Officer C again asked Senior Officer A whether Prisoner A could move and Senior Officer A again referred the matter to the Governor, who was head of residence agreed it. Senior Officer A told my investigators that she did not think this was a healthy move but that she was not concerned for the safety of either Prisoner A or the woman.
105. In interview, the Governor who was head of residence said that at the time he had not been aware that the woman and Prisoner A were in a relationship or that the woman had previously moved from A wing. No one had told him they believed the move was not a good idea and he therefore had no reason to object. If anyone had raised any concerns, he would not have authorised the move.
106. The staff observation book for B wing notes that Prisoner A moved there in the afternoon of 23 January. She was told by Senior Officer B that this would be her last chance to make progress at Foston Hall. The entry noted that Prisoner A appeared happy with the move.
107. Prisoner A told police that she had begun having problems with some of the staff on A wing and she therefore wanted to move to B wing to have a fresh start. She had told the woman that, even if she had not been located on B wing, she would have asked for a transfer there. Prisoner A put in a request to move and this was approved by the senior officer of B wing straight away.
108. Officer A had been on annual leave when Prisoner A was moved to B wing. When she returned she was surprised about the move because she had thought the reason the woman had been relocated was to “alleviate the tension and arguments”. However, she did not discuss this with anyone.
109. Prisoners similarly expressed surprise to my investigators that Prisoner A had been allowed to move to B wing. They had differing opinions regarding how the woman felt when Prisoner A was moved to B wing. Some said that they believed the situation became overwhelming for her, and that she was down and withdrawn and would often go to A wing for association. Other prisoners overheard arguments between the pair, with Prisoner A being more vocal and doors or walls being punched or kicked when they were arguing. Others believed that the woman seemed happy when Prisoner A was first moved to B wing, but that her mood subsequently deteriorated.
110. Prisoner A told the police that, following her move to B wing, her relationship with the woman was “good”, without any arguments until the day before she died.

111. In their last session, on 23 January 2009, the seconded probation officer had asked the woman about her relationship with Prisoner A as he was aware that they were both now located on the same wing. She told him that she was not in a relationship with Prisoner A and that they were just friends.
112. Around this time, the woman's application for funding for a distance learning course to the Prisoners' Education Trust was refused. A member of staff (Staff C), who works in the careers information and advice service, passed on the news to the woman on 27 January. She told my investigators that she tore up the letter and she had tried to explain that it was not a personal decision against her. Staff C was concerned about this reaction and therefore spoke to the seconded probation officer who agreed to see her to ensure she was coping with the decision. It is not clear whether this meeting took place.
113. Staff B spoke to the woman on 28 January about the decision by the Prisoners' Education Trust not to fund her course. She said the woman was extremely disheartened, saying that everyone had always told her she was a failure and now she had proven them right. She told Staff B she would now no longer make an effort and just watch television like all the other prisoners.
114. On 29 January, Prisoner D forgot to pass on a message to sanctuary staff. This was a message which Prisoner A had originally given to the woman to pass on. Prisoner D said this resulted in Prisoner A arguing with the woman. Prisoner B also witnessed this argument. Prisoner D said the woman left work early that day, which she had never done before, because she was so upset.
115. Prisoner A told the police that she went to see the woman after finishing education on 29 January. She said everything between them was fine at that point and they were laughing together. Around 30 minutes later, she saw her again but thought her mood had changed and she seemed upset with her. She followed her up to her room to check on her but she did not want to talk. Prisoner A told police that the woman came onto the landing and started shouting at her, so Prisoner A left to go back to her room.
116. Prisoner A said that, just before 5.00pm, the woman came down to her cell. They had a brief conversation and were then locked into their own cells.
117. She telephoned her son at around 6.00pm that evening. My investigators listened to a recording of the conversation. She made references to the future and sounded cheerful, at no point alluding to any difficulties she was having in prison. She also spoke to one of her son's guardians.
118. Prisoner C told the investigators that the same evening the woman came to her room, looking upset and saying that she had had a big argument with Prisoner A. She then carried on the conversation with another prisoner, Prisoner E, who was also in the room.

119. Prisoner E told the investigators that when the woman came to Prisoner C's room that night she was much more affectionate than usual, and gave her a hug and would not let go. The woman told her about the row she had had earlier with Prisoner A over the message she had forgotten to give staff. She told her about the debt she had built up trying to get Prisoner A's tramadol, how stressed she was about it, and how she was also trying to save up for a town visit but was unable to. (A prisoner may be allowed out on day release on a town visit near the prison with a member of staff accompanying them. Such visits are linked to the IEP system and only used when a prisoner has reached a point in their sentence where they are preparing for release back into the community.)
120. She also told Prisoner E that she had gone to the doctor to try and get a prescription for tramadol. The woman then asked what she should do and Prisoner E advised her to speak to Prisoner A. Prisoner C and Prisoner E both said that the woman left the cell between 7.00-7.20pm to try and resolve the earlier argument with Prisoner A .
121. Prisoner A told police that she came to say goodnight to her and asked her to come up to her cell so they could resolve things. She noticed that the woman was acting very out of character in that she was short-tempered. They started arguing, Prisoner A felt angry and either punched or elbowed the bathroom door. The woman herself became angry and started walking towards her. Prisoner A told police she knew the woman was not going to hit her, but as a reaction she grabbed her by the throat and pushed her against the wall. Prisoner A told police she then let go, left the room, and could hear the woman smashing things in her room as she left. She said that this was the first time their relationship had ever become violent and it was their worst argument.

### **30 January**

122. Officer B said that on the morning of 30 January she realised Prisoner A was also located in B wing when she was collecting another prisoner. She therefore made a note in her diary to go and see the woman as soon as she could, given their previous discussion about her relationship with Prisoner A
123. Officer H began her shift at 8.00am that day and was working with one other officer (Officer I), on the wing. Prisoners were unlocked at 8.15am for breakfast, then those who were not going to work were locked back in their cells. Officer H remembers seeing the woman go to work that morning but she did not speak to her.
124. Another prisoner, said that she saw the woman waiting outside Prisoner A's room straight after they were unlocked in the morning. She saw her looking through the observation flap and then pacing outside Prisoner A's room.
125. Prisoner A said that she brought her a compact disc that morning. Prisoner A asked her if they were going to resolve their difficulties, to which she replied, "I thought you finished it last night?" Prisoner A explained to her she had not

finished their relationship but did not want to keep on arguing. The woman then said to her, "I don't plan on being here in three days," to which Prisoner A replied, "What do you mean, you gonna kill yourself or get an emergency transfer out or something?" she replied, "Whatever I do will be my responsibility". Prisoner A said she genuinely thought she meant she was going to get a transfer to another wing and did not discuss this conversation with staff.

126. Prisoner A told police that they continued arguing about the events the day before. Prisoner A put her hands on her head and slid down the bedroom wall and said, "I can't do this any more." She went into the bathroom, shut the door and told the woman to leave as she could not cope with any more of the arguing. She then left the room. Prisoner A saw her later in the sanctuary, when she was on her way to education at around 9.30am. Prisoner A therefore assumed she was "OK".
127. Prisoner B was also working in the sanctuary that morning and said in interview that the woman arrived much earlier than usual for work at 8.15am. She also left much earlier than usual to go back to the wing, and did not return to the sanctuary as she often would on Friday afternoon.
128. Prisoner D arrived for work at the sanctuary at around 9.15am that morning. She asked the woman why she had arrived at work early and she replied, "I had to get off the wing, it was either that or cut up". She told her that she had punched a hole in her door. Although she had apologised to Officer H, she was worried about the repercussions. She jokingly spoke about hanging herself but Prisoner D did not believe that she was serious. She told the investigators they had previously had similar conversations where they joked about such things. Prisoner D did not pass on any of this information to staff as she did not want to betray her confidence.
129. Prisoner D had noticed what appeared to be scratches on the woman's neck and asked her about them. She told her she had done them in her sleep but Prisoner D did not believe her. Prisoner D said to her, "What are you going to do because you're not happy at all ... you look wiped out, there's nothing left of you?" she did not respond.
130. Another prisoner, also worked with the woman that morning. She told the investigators that she seemed in a "daze" and, when she asked what she was thinking about, she did not get a response. At around 10.30am, she seemed agitated as she wanted to leave work but had to wait for another prisoner to return to cover for her. The prisoner told my investigators that she kept saying she had to go and see someone. As soon as the other prisoner returned, the woman left without explanation. The prisoner said this was unusual.
131. Officer H saw the woman when she returned from work at 11.00am. She said she did not want lunch and asked to be locked in her cell, which Officer H did. Officer H explained to the investigators that locking her in meant she was unable to leave her cell, whereas if she just closed the door with her passkey

she could open it from the inside. However, Officer H wondered why she had asked to be locked in and therefore went to check on her. She explained she wanted to have a shower and clean her room and, since she was cleaning her room at the time, Officer H had no reason to question this. She was acting normally and denied anything was bothering her.

132. Officer H also told my investigators that it was not unusual for her to refuse her lunch as she often said they got the meal wrong when she ordered the vegetarian option. The woman's food refusal was not noted anywhere as it was only occasional. Had it been regular, it would have been recorded but she had eaten her breakfast that morning. Officer E agreed with this, saying it was quite usual for her to miss her lunch and she would often come and collect it late when she returned from association on A wing.
133. Prisoner A told police that she did not go to see her when she returned from education as she thought she needed some space. She asked one of her friends to check if the woman was OK. Her friend did so immediately and reported that she was changing her work clothes and seemed fine. Prisoner A was then locked in for lunch and was not unlocked until 2.30pm. She said this was unusual as they were normally unlocked at 1.30pm. At the time, Prisoner A believed the delay was due to the woman being transferred off the wing.
134. At 12.30pm, either Officer H or Officer I completed the roll check, during which they should have made sure they got a response from the woman. (The officers could not remember which of them had completed this.) At 2.30pm, Officer E arrived on B wing and all the prisoners were again unlocked. The officers could not remember who had unlocked the woman's cell but they would not have been expected to check on each prisoner at this stage, unless they were subject to the Prison Service suicide prevention measures known as ACCT.
135. Prisoner F occupied the cell opposite the woman's. Prisoner F told my investigators that she saw her after they were unlocked following lunch and asked if she was alright, to which she responded positively. Prisoner F did not see her again during association and assumed she had gone to A wing or to work. Prisoner F noticed the woman's cell door remained closed for the association period.
136. As soon as she was unlocked at 2.30pm, Prisoner A went to see her. As her room was locked, Prisoner A looked through the observation panel but could not see her. At the time, she thought that she had gone to A wing. Prisoner A went back to her room numerous times during the afternoon to check on her. During the whole afternoon she did not see the woman and her room did not appear to have changed.
137. Just before being locked in her cell, Prisoner A again went to the woman's cell to see if she was back. It was dark so she switched on the night light outside the cell. She left three muffins with Prisoner F for her to give to the woman

once she returned. Prisoner A then went back to her own cell at 5.20pm ready to be locked in.

138. At the same time, Officer H was locking the prisoners in their cells. Before doing so she checked each prisoner was in their cell. When she got to the woman's cell she could not see her. It was dark, the curtains were closed and the light was switched off. Officer H therefore assumed she was downstairs in Prisoner A's cell. She continued to shout for her and, once she had locked all the other cells, returned to her cell. On her way back, Prisoner F asked if she could give the muffins to the woman, which Officer H subsequently placed in the woman's cell.
139. Officer H then noticed that the bathroom door was shut and there was something wedged against it. She assumed the worst and therefore immediately used her radio to call for medical assistance. She managed to get into the bathroom and found the woman on the floor by the door but did not immediately see that there was a ligature around her neck. She moved her away from the door to allow others access to the bathroom when they arrived. She realised the woman was cold to the touch, and blue in colour. She could not find a pulse. Officer H also noticed that the woman's hands were slightly stiff.
140. Officer E arrived at the cell moments later and cut the ligature (a dressing gown cord) from the woman's neck. It was not attached to anything. Officer E noticed a red mark under where the ligature had been and some blood on the end of the woman's nose.
141. Officer J told the investigators she was on another wing when she heard a call for medical assistance over her radio. She went straight to the woman's cell with Officer K. When Officer J arrived at the cell she saw Officer E standing at the door and Officer H standing over the woman in the bathroom. She directed Officer H out of the cell for her own welfare. She could not detect the woman's pulse and therefore started resuscitation attempts, mouth-to-mouth, while Officer K did the chest compressions at the correct ratio of 30:2. The woman was cold to the touch and quite pale.
142. The HCA said that she was working in healthcare when she heard the call for emergency assistance to B wing. She picked up the red bag and made her way to the woman's cell. She explained to the investigators that the red bag mostly contained items needed if somebody had a bleeding wound, but it also had other emergency equipment such as an ambubag (used to aid resuscitation) and airways equipment. When she arrived at the cell, she saw the two officers completing chest compressions and she noticed the woman was blue. The HCA therefore radioed asking for further assistance which would include a defibrillator (a portable electronic device which measures electrical activity in the body and advises on action to be taken) and oxygen.
143. The HCA looked for signs of life, including breathing or a pulse. At that stage the head of healthcare, also arrived. She asked for an ambulance to be called immediately, and this is recorded on the communications incident log at

- 5.25pm. A minute later, the Site Manager, who happened to be in the control room rang 999 and requested the ambulance. He was unaware that the emergency was a hanging, or that the woman was not breathing, and therefore the emergency services were not given sufficient information to correctly prioritise the urgency of the call. Meanwhile, Officer G had also heard the call for medical assistance and arrived at the woman's cell.
144. The Head of Healthcare and Officer G then left to get a defibrillator and oxygen from the healthcare centre. The Health Care Assistant took over administering the breaths to the woman. She told my investigators that the woman's mouth seemed quite stiff and it was difficult to get breaths in, but she did so successfully and saw the woman's chest rise. Officer J, the HCA and Officer K then continued resuscitation attempts in rotation.
  145. East Midlands Ambulance Service (EMAS) logged the call from Foston Hall at 5.29pm. The request for an ambulance was given an amber despatch code which means that the target response time for the crew is to be with the patient is within 19 minutes in 95 per cent of calls.
  146. The Duty Governor had responsibility for responding to any alarms at a governor level. Following the call for medical assistance over the radio, he then heard a request for him to go to delta wing. On his way there he met the head of healthcare who asked him to go to the woman's cell with him. He agreed to this since he knew the other request had not been an urgent one. In interview he said it was a judgement call which radio requests the Duty Governor attended.
  147. The Duty Governor arrived at the cell, along with the orderly officer, Principal Officer (PO) B. PO B said that at Foston Hall they also have an 'urgent medical assistance' call but this had not been flagged as such. He said its priority was therefore slightly lower than a general alarm or urgent message.
  148. The Duty Governor saw staff trying to resuscitate the woman and he checked that they had all the equipment they needed. The woman appeared blue and mottled. The Duty Governor confirmed that an ambulance had been called over the radio and was told that it would be 18 minutes before it arrived. He told the control room that this was unacceptable and they needed an ambulance faster. The Governor ensured that PO B had made arrangements to allow the ambulance entry to the prison
  149. As a result of the Duty Governor's request, at 5.35pm the site manager dialled 999 to ask that the ambulance be despatched more quickly. The EMAS records show that this second call logged that the emergency was a hanging and the call was upgraded to a red despatch code. This meant that the target response for the crew to be with the woman was within eight minutes in 75 per cent of calls.
  150. In interview, Officer G estimated she returned with the emergency equipment around four to five minutes after the original call for medical assistance. She also gave the HCA her face shield as she had been getting blood in her

mouth from administering the breaths. There was no face mask in the emergency bag and Officer G said it is left up to personal preference as to whether an individual carries one.

151. Nurse E and Officer G then attached the oxygen and defibrillator to the woman which indicated “shock not advised”. This meant that there was no electrical activity in the woman’s heart. The HCA said staff continued resuscitation attempts with The Head of Healthcare holding the face mask in place for her, while Officer J completed the chest compressions. Officer G noticed that the woman’s neck and jaw were very rigid, and she was grey in colour. In her opinion, rigor mortis had started to set in.
152. The nurse then attached the defibrillator again which indicated “shock advised” twice and these instructions were followed. However, there was no change in observations and resuscitation attempts continued.
153. The paramedics arrived between 5.48pm and 5.52pm and attached their electrocardiogram (a machine which measures the heart’s electrical output) to the woman. She registered as asystole (no electrical activity) which indicated that she had died. The paramedic certified death at 5.54pm. At 7.30pm, this was confirmed by Doctor D, who was attending the prison in connection with an unrelated matter.
154. During the resuscitation attempts, Officer E had left the cell to speak to the other prisoners on the landing to check their welfare. The woman had left a letter addressed to her son in her cell.

## **Staff and prisoner care and family liaison**

155. The Duty Governor held a debrief shortly after the woman's death which focussed on ensuring the welfare of colleagues and prisoners. Twenty-one members of staff attended. As there were a number of very distressed staff, he was focussed on making sure that they were looked after. The care team had arrived by this point and he was prioritising who they saw first, as well as making sure he spoke to everyone himself. He told staff how proud he was of them and their efforts to save the woman.
156. The care team also offered support to the Duty Governor. The Governor and the Deputy Governor subsequently spoke to him about his welfare and how successfully he had managed the situation. The Governor held another debrief to reinforce how proud of the staff he was and how hard they had all worked.
157. The staff response to the care and support they received following the woman's death was positive. Those involved in resuscitation efforts said they were seen immediately by a member of the care team and have been offered ongoing support as needed. All other members of staff said that they were adequately supported by peers and managers.
158. In relation to the care of the prisoners, the Duty Governor increased the number of staff patrolling the residential areas. He also ensured that those subject to ACCT suicide prevention measures were spoken to a little while later. It was decided that prisoners in the immediate vicinity would be told that night as there had been a lot of noise while they tried to resuscitate the woman and they would have seen the ambulance arriving and leaving. The prisoners from B wing were unlocked and gathered in the association room around 11.00pm. Some prisoners found this to be a negative experience since they were not allowed to remain in the association room afterwards to comfort each other but were locked back in their cells for the night. They believed this news could have waited until the morning.
159. Staff did not tell those on other wings until the next day as they would have been unaware of the emergency. The Samaritans were called in to support the Listeners (prisoners trained to provide peer support) once the prisoners had been told. However, they wanted to tell the family the news first.
160. It was not possible to appoint a family liaison officer immediately as both trained members of staff were on annual leave. The Duty Governor said in interview that the next of kin details they held for the woman were wrong, listing the woman's mother with whom she had not had contact for thirteen years. He therefore contacted the police to obtain the correct details of the woman's son and guardians. The Duty Governor consulted the Governor and they decided that, since the next of kin were some distance away, they would ask the police to go to their home.
161. In the meantime, the police visited the woman's son and his guardians, told them about her death and gave them the Governor's direct dial number. The

family called him a short time later. The Duty Governor and the Governor agreed to go and see the family immediately as was their wish, arriving around 1.30am.

162. The wing observation book notes that another prisoner was located with Prisoner A for the night to support her. Following several SIRs being submitted and information gathered from staff talking to prisoners, Prisoner A was moved to another prison on 6 February 2009. This was because a number of prisoners blamed her for the woman's death.
163. The Governor who was head of residence was subsequently appointed as family liaison officer but did not return to work until 6 February. The Governor therefore telephoned HMP Gloucester and spoke to a Governor who told the woman's husband the news of her death on 31 January. The Governor was also told by the Deputy Governor at Gloucester that her husband was happy for the woman's son to act as the next of kin.
164. Over this and following days, the Duty Governor kept in contact with the woman's son and his guardians on a daily basis. This was partly to maintain contact and offer any help they needed but also to keep them up to date with the police investigation and post mortem process. He also told them, and confirmed in a subsequent letter of condolence, that the prison would pay for and assist in organising the funeral. The Duty Governor also spoke to the woman's son who asked about the possibility of a mass being held for his mother. This was arranged for 6 February.
165. Also on 6 February, the Duty Governor received a telephone call from the woman's husband. They discussed the circumstances surrounding her death and the ongoing investigations. He told the woman's husband that a Governor was their family liaison officer, and he would visit him as soon as possible. The Duty Governor also told the woman's husband that they would hold a Buddhist service to coincide with the woman's funeral, as she had recently become a Buddhist.
166. The same day, The Duty Governor arranged for the woman's son and his guardians to visit the prison to meet him and attend the mass being held in her memory. The Governor who was acting as their family liaison officer he was the head of residence) returned from leave on this day and also attended this meeting to introduce himself.
167. He took over all further liaison with the family and went to their home when he explained more about property, funeral arrangements and the procedures following a death in custody. The woman's funeral was held on 27 February, attended by the Governor acting as their family liaison officer and the Governor who was head of performance delivery.
168. The Governor acting as the family liaison officer remained in contact with the family after the funeral and visited them on 19 March to check on their welfare. He then contacted them on a monthly basis until June when he left Foston Hall. The Reverend took over as the family liaison officer and

contacted the woman's husband, son and fellow prisoners in the days leading up to the anniversary of her death.

### **Post mortem**

169. The post mortem conducted by a Professor concluded that the woman died as a result of hanging. The Professor found there were fresh self-inflicted injuries to the right upper leg which he believed had been caused around one day before she died. He also found wounds just above the left knee which he believed to be self-inflicted, caused around a week before she died. Although two prisoners told my investigators they were aware she had self-harmed in this manner, they had not passed on this information to staff as she had not wanted them to. Given the location of the wounds, staff were unaware she was self-harming.
170. The toxicological examination identified the presence of a number of drugs in the woman's body. Tramadol was present within the reported lethal range. The Professor concludes that, although this neither caused nor contributed to the death, she might have consumed this quantity as part of her suicidal intention.

## **ISSUES**

### **The delay in the woman receiving a psychology appointment**

171. One of the main reasons for her transferring to Foston Hall was to complete psychological sessions, with the hope of being approved for open conditions by the Parole Board. She spoke to several members of staff regarding her frustration at not receiving an appointment until January 2009, around seven months after she was transferred to Foston Hall. However, there had been no delay in her being referred to the psychology department and she was kept informed of the expected waiting time. Indeed, she completed the first part of her psychological assessment around two weeks before her death and, in a telephone call to her son's guardian, said she was relieved about starting this work.
172. An investigator spoke to the Acting Head of Psychology, regarding waiting times for psychological intervention. She explained that at the time of the woman's death there had been a long waiting list. This was due to staffing levels and vacancies within the team. She would have expected the woman to be kept up to date with this. This appears to have been the case.
173. The Acting Head of Psychology said that prisoners would be prioritised on a needs basis and, since the woman's needs were linked to her application to move to open conditions, this would be seen as a higher priority. However, despite this, a wait of six months would not have been unusual.
174. As of January 2010, the Acting Head of Psychology said the team was still significantly understaffed and there could be long waiting lists for prisoners. However, she also understood that due to future budget cuts at Foston Hall it may be that these posts will not be filled and the psychology team will continue at its current capacity.
175. Realistically, it seems possible that a waiting list will remain for psychology appointments at Foston Hall. A number of staff spoke to the woman regarding her frustrations about the delay to her appointment and she was kept up to date with the likely schedule for it to take place. I therefore do not make any formal recommendation, although it is manifest that delays in conducting psychological assessments are undesirable.

### **The woman's personal officer**

176. The Governor acting as the family liaison officer told the investigator he thought the personal officer process had improved and was more robust since the introduction of the offender management system. He believed life sentenced prisoners had benefited as the offender management unit had an open door policy. Therefore, prisoners could either go to their lifer manager, offender manager or, on the wing, to their personal officer.
177. It is unclear from the woman's file whether she was allocated a personal officer as soon as she arrived at Foston Hall. The first reference to a personal

officer in her record is over two months after she arrived, on 20 July 2009, when Officer L introduced himself as her personal officer. He made fortnightly entries in her wing history sheet until 9 September when Officer A became the woman's new personal officer. Officer A made two entries in the woman's wing history sheet, the last being on 17 September. She made no reference to either the woman's move to B wing or move to work in the sanctuary.

178. The next entry in her file is dated 27 December, completed by Officer D, the woman's personal officer following her move to B wing. There is only one subsequent entry about her attending a hospital appointment. It is clear from speaking to Officer D that she did sentence planning work with the woman that is not recorded in her wing history file.
179. Foston Hall has now moved to P-NOMIS, a computerised system of recording information, including personal officer contact. Whilst I again make no formal recommendation in this regard, wing managers may wish to check (i) that all prisoners are consistently allocated a personal officer and (ii) the regularity with which the personal officer records information and decisions about a prisoner.

### **Handling personal relationships**

180. The majority of staff of all grades and disciplines seemed to be aware of the relationship between the woman and Prisoner A, except for some of those for whom it was most crucial - for example, officers on B wing where the woman moved and the Governor that became the family liaison officer. Most staff who were in the know commented that they did not believe it to be a positive relationship and were concerned for the two women's welfare at some point. However, little seems to have been done to challenge the woman and Prisoner A regarding the negative elements of their relationship.
181. Both staff and prisoners described the woman as a very private person who would not share her difficulties unless she decided she absolutely had to. On several occasions, she also denied to staff that she remained in a relationship with Prisoner A. However, evidence of their arguing and volatile relationship continued. It seems this evidence was held by individuals rather than being recorded centrally for all to share.
182. For example, when she moved from A to B wing the consensus amongst staff and prisoners on A wing seems to have been that this was to get some space from Prisoner A. However, these reasons are not recorded anywhere so her new personal officer on B wing was unaware of her relationship with Prisoner A or her reasons for relocating. Similarly, other officers on B wing said they were unaware of the relationship.
183. Again, when Prisoner A then moved to B wing some staff said they were surprised by this move and did not think it was a good idea due to the nature of the relationship between the woman and Prisoner A. However, these thoughts were not conveyed to the Governor who was head of residence. As a result, he was unaware there was any friction between Prisoner A and the

woman, or that they were in a relationship, and therefore agreed to the move. The Governor told the investigation that, had he known any of this information, he would not have authorised Prisoner A's move.

184. The Governor who was head of residence said he was aware that information was not always passed on from the offender management unit to the personal officer. However, he was trying to improve systems to help this information sharing across staff at the prison.

185. Of course, this situation was made more difficult by the woman herself requesting Prisoner A's move to B wing, although some staff were concerned about her reasons for this. It seems these reasons may not have been explored fully with her.

186. Foston Hall's decency policy (revised January 2008) indicates that unacceptable behaviour includes: sexual relationships, kissing, fondling, walking round with arms around each other or holding hands, joint association in a room with a door closed or light off, or lying on or in bed together and sitting on each other's laps. It also notes that:

"Wing changes may be made by prisoners as a direct result of a new relationship being formed. Staff should not permit a request for room or unit moves to facilitate such relationships and no room moves will be carried out without express permission from the wing SO with full reasons to be given on any application. Prisoners should also be reminded that should any inappropriate behaviour be brought to the attention of staff then it may result in relocation to another wing."

187. The policy also states:

"It is not acceptable for staff to condone intimate relationships between prisoners as this can cause friction within the prison and may lead to bullying investigations when relationships break down. Identification of a relationship forming should be discussed with wing managers immediately and appropriate action taken."

188. The woman and Prisoner A's relationship does not seem to have been addressed in line with the decency policy. The Governor who was head of residence explained the difficulty in judging when two women are in a relationship as friends often walked arm in arm and they are allowed to associate in each other's rooms. He said the rules are that the lights stay on and the doors open but, unless a couple are clearly found to be breaching the decency policy, there is little staff can do. The Governor was somewhat surprised that some staff working with the woman were unaware of the issues she faced. However, he believed that staff-prisoner relationships were excellent at Foston Hall and prisoners had no problems at all talking to staff.

189. Officer B also said it was often difficult to judge the distinction between a 'relationship' and 'companionship' as women were often more affectionate towards each other in prison and relationships might be used as a coping

mechanism. She said it was hard for staff to make that judgement and she believed they were often in “limbo”, not knowing what action to take. She believed staff would often not intervene in something they thought was a relationship if the two people concerned were not causing any problems.

190. Whilst I acknowledge these difficulties and recognise that women often form close relationships in prison, it also seems that more could have been done to challenge both the woman and Prisoner A regarding their relationship with each other. It was clear to some staff that the relationship was unhealthy and the decency policy provides for managers to take appropriate action. Such information would have been especially important with regard to their subsequent wing changes. I therefore make the following recommendations:

**The Governor should ensure that staff are clear when and how to challenge relationships between prisoners, particularly when it is evident that there is friction.**

**The Governor should remind staff that contemporaneous records should be kept on P-NOMIS with regard to prisoners’ concerns and decisions affecting them.**

#### **The woman’s disclosure of violence**

191. Staff and prisoners heard arguments between the woman and Prisoner A, with Prisoner A often described as being the more vocal. A number of prisoners also believed Prisoner A was violent towards her, either because one of them had admitted this or they had heard the arguments which occurred between the pair, or they had seen unexplained injuries on the woman.
192. In September 2008, she disclosed to Officer B that Prisoner A had been violent towards her, hitting her, grabbing her throat and spitting at her. Officer B spoke to Officer A, the woman’s personal officer, and they agreed that Officer A would observe her and note these concerns in the wing history sheet. There is nothing documented in the woman’s record or the wing observation book to this effect. Officer B noted the content of her conversation with the woman in her CARAT record. During interview, no other member of staff indicated that they were aware of the potentially violent nature of the woman’s and Prisoner A’s relationship.
193. Foston Hall’s violence reduction strategy states:
- “... staff should encourage the reporting of incidents as a positive action, and ensure that all reports are taken seriously and dealt with appropriately ... all violent incidences or threats of such by prisoners must be recorded and will be dealt with in an appropriate manner.”
194. The strategy states that all violent incidences must be recorded in the wing observation book, the prisoner’s wing history sheet, in a security information report or memo, and in any violence or anti-social behaviour investigation

documentation. The policy says that this information should be communicated between staff as necessary. The policy indicates that, following this, there are two alternative stages of intervention that can be followed.

195. The first stage is called early intervention:

“... a method that staff can use to deal with issues of conflict at an early stage such as potential violence, minor conflict or early threats of arguments or challenges, or if staff see an altercation between prisoners.”

196. The policy says that this stage will ideally avoid escalation into seriously harmful incidents and does not result in the prisoner being placed on a disciplinary charge. It involves talking through the issues in an informal meeting with the prisoners involved and their personal officer or wing senior officer to gain an agreement the behaviour will not continue. Following this, the prisoners must be monitored to ensure that there are no further incidents and details of the meeting recorded.

197. The policy indicates that this process should be used to deal with minor conflicts but, if the conflict continues or if a prisoner's behaviour observed or reported is clearly of an unacceptable nature, then second stage intervention measures must be invoked. This stage involves a formal violence or anti-social investigation.

198. The woman's disclosure to Officer B (subsequently passed on to Officer A) that Prisoner A had been violent towards her should have resulted in at least a first stage intervention, with her and Prisoner A being invited to an informal meeting. Whilst there is no proof that any violence occurred, the woman's assertions should have been investigated and at the very least, recorded in her own wing history sheet, Prisoner A's history sheet, and the wing observation book. The information should also have been recorded in an SIR.

199. While staff involved certainly made the effort to provide her with more space from Prisoner A by moving her employment and location on the wing, the reasons for this move are not documented within the woman's paperwork. It does not seem to have effectively solved the problem, since Prisoner A herself admits to being violent towards the woman the night before she died. I therefore recommend that:

**The Governor should remind staff of the contents of the violence reduction strategy policy including the need to report, record and communicate all incidents of violence and act on these as appropriate.**

### **Prescription of isotretinoin**

200. Isotretinoin was prescribed to the woman on 28 November 2008 and her dose was doubled on 21 January 2009. The clinical reviewer notes that in Derbyshire County Primary Care Trust it is:

“... classified as a red drug, which means that prescribing responsibility lies with a hospital consultant or specialist and it should not be prescribed by GPs. The concerns around Isotretinoin relate to the risk of teratogenicity (abnormalities of development) if a woman becomes pregnant whilst on the drug and also the effects on mood.”

201. The clinical reviewers also refers to the advice of the British Association of Dermatologists (BAD) that there are unproven suggestions that isotretinoin can produce mood change, regardless of whether the patient has a prior history of mental illness or not. BAD also advises that a direct enquiry about a patient’s psychiatric health should be made for all those being considered for isotretinoin and the facts recorded fully in the notes. The advice goes onto say that all patients should be made aware of the potential for mood change in a “realistic, non-judgemental way, and should be advised to ask their family and friends to comment if such a change should occur.” Lastly, BAD advise that a “direct enquiry about psychological symptoms should be made at each clinical visit”.
202. The clinical reviewers, found little evidence that this advice had been followed at Derbyshire Royal Infirmary, albeit noting that the link to mood change and suicide is unproven.
203. The clinical reviewers also note that on 2 February 2009 the Administrative Officer working in healthcare, called Doctor C’s secretary to inform her of the woman’s death and was told by the secretary that Isotretinoin is associated with depression. The clinical reviewers also interviewed the Head of Healthcare who said she was unaware of any issues around the medication and mood changes. In such situations it might be prudent for healthcare staff to ensure they are aware of the side-effects of any medication prescribed by outside hospitals.
204. Although outside my remit, I note that the clinical review has recommended that Derbyshire PCT is informed of the circumstances of the woman’s death and that they conduct a significant event analysis around the prescribing of isotretinoin to her to check that BAD guidance was followed.

### **Levels of tramadol found in the woman’s post mortem**

205. The toxicology report notes that tramadol was present in the woman within the reported lethal range. The Professor concludes that, although this neither caused nor contributed to her death, it might have been taken to this level as part of the woman’s act of apparent suicide. Since she was not being prescribed this medication it is of evident concern that she had it in her possession.
206. As discussed previously, she had been interviewed as part of a violence and anti-social investigation involving the trading of tramadol. She had denied obtaining tramadol for Prisoner A. While most prisoners believed that she was involved, they did not pass on information to staff and it is therefore

difficult to ascertain how the woman's involvement could have been proven at this stage.

207. If she did obtain the drug, it is impossible to know whether she did so for herself or originally for Prisoner A. I make no recommendation in this regard.

### **Call for medical assistance**

208. When Officer H noticed the woman's bathroom door was wedged shut she immediately feared the worst and called for medical assistance over her radio. Clearly getting her medical attention as quickly as possible was the appropriate course of action.
209. However, the Duty Governor said that there could be around twelve calls for medical assistance every day and, if he did not hear anything over the radio after the first call, he would usually check the progress of the call after a couple of minutes over the radio. Despite the regularity of these calls, he believed staff would always attend the radio call as quickly as they could.
210. The HCA said that there are no specific codes for calling for medical assistance, but that communications would often give instructions, such as 'take oxygen', or otherwise communicate the urgency required. However, she would be unaware until she reached the location regarding the nature of the emergency, for example if somebody had cut themselves or stopped breathing. The HCA explained that there was only one defibrillator located in healthcare. This would not normally be initially carried to the emergency but would be requested once healthcare had reached the prisoner. This was because it is too much equipment for one person to carry.
211. An officer and a member of healthcare staff reached the woman's cell and then had to leave to get the defibrillator and other emergency equipment. Given that early defibrillation is often cited as a critical factor in the success of a resuscitation attempt, any delay to its arrival should be minimised. I accept that, in this instance, it would have made no difference to the woman's chances of survival, but it could be so in the future. I therefore make the following recommendation:

**The Governor should consider implementing a code system to notify medical staff about the nature of an emergency to enable them to take the right equipment to each situation.**

### **Resuscitation attempt**

212. The clinical reviewers have considered whether attempting cardio pulmonary resuscitation (CPR) on the woman was appropriate given that it seemed likely she had been dead for some time when found. They conclude, "It would seem inappropriate and unsafe to suggest that non-medical staff should make the decision not to resuscitate anyone they found who was not breathing and had no pulse."

213. The Head of Healthcare, outlined that Prison Service Order (PSO) 2700 on suicide prevention and self-harm management gives instructions on emergency procedures. In a case of hanging, staff are instructed to commence resuscitation unless rigor mortis has clearly set in. Since the prison officers had already started resuscitation, the Head of Healthcare felt she was duty bound to support this.
214. Whilst resuscitation attempts clearly have to be balanced against the patient's need for dignity, in this case officers and healthcare staff acted as a team with the best possible intentions.
215. The clinical reviewers note that, following an internal review, it has been decided that all nurses and trained officers will carry pocket resuscitation masks when on duty.

### **Resuscitation training**

216. Resuscitation was undertaken within current guidelines and the Head of Healthcare was satisfied that the airway was clear and there were sufficient staff to complete resuscitation competently.
217. The clinical reviewers note that all the nursing team are trained in resuscitation and use of the defibrillator. They also have annual updates organised through Derbyshire PCT. Some officers have resuscitation training at an early stage in their training and others are trained in first aid at work. There is always an officer on duty with one of those skills.
218. However, there is no system for regular resuscitation update training for discipline staff. The clinical reviewers suggest that the Governor considers training all staff in basic resuscitation so that, if a prisoner stops breathing in the future, air entry and circulation can be maintained until healthcare staff arrive to take over more advance resuscitation. I also suggest that prison staff be given regular refresher training. Given the prevalence of self-harming behaviour in women's prisons, I endorse the clinical reviewer's recommendation:

**The Governor should consider ensuring that all prison staff receive CPR training, such as Heartstart, on an annual basis.**

### **Calling the ambulance**

219. Thirty-one minutes elapsed from the time the woman was found until the paramedic arrived at her cell. The clinical reviewers examined the process taken to determine whether there were any avoidable delays.
220. An ambulance was not called until healthcare staff arrived. The clinical reviewers have found that the prison procedures require the first person to arrive at the emergency to call for immediate medical assistance and/or an ambulance. An ambulance should therefore have been called at 5.17pm,

along with the call for medical assistance as it was clear the woman needed resuscitation.

221. It has been a requirement since September 2004 that each Governor ensures their prison has a protocol in place with their local ambulance service. A letter from the Department of Health to the Governor of each prison, dated 22 March 2004, noted:

“It is also essential that internal procedures should not waste undue time in summoning emergency assistance. It should not, for example, be a requirement in every case for a member of the healthcare team to attend the scene before emergency services are called. However, a subsequent 999 call to the Ambulance Service should be made to cancel the response if, after the original 999 call has been made, a member of the healthcare team arrive with the patient and deem that an emergency ambulance response is not required.”

222. However, the ambulance protocol agreed between East Midlands Prisons and East Midlands Ambulance Services, dated January 2008, gives conflicting instructions. It indicates:

“In all cases, prior to an emergency ambulance/paramedic team being summoned, a member of healthcare staff, if on duty, are to attend the scene to determine the required level of support and this information must be given to the communications officer (control room staff).”

223. PSO 2710, follow up to deaths in custody, notes that, “Local contingency plans must provide for the summoning of an ambulance and alerting key personnel and state clearly who should do this.”

224. Foston Hall’s suicide prevention policy (2008) details the action to take following the discovery of a prisoner who may have died. It does not indicate who should call the ambulance and at what stage.

225. The first request for an ambulance was made at 5.25pm at the request of the Head of Health Care. The 999 call was made at 5.26pm by the Site Manager who happened to be in the communications centre collecting a telephone when the emergency occurred. He offered to call 999 to help the communications staff.

226. Staff in the communications room could not see the emergency and therefore had to rely on the information they received from staff at the cell to relay to EMAS. EMAS uses a protocol, including a series of questions, to assess the urgency of a call. The clinical reviewers listened to a tape of the first call to EMAS and noted:

“It is clear that the caller did not know the answers to the questions being asked although he was trying to get more information from the incident scene. At one point he asked if the woman was breathing and states that she was. He also stated that prison medics were on the scene. The initial

call was coded amber by EMAS. It would seem that this was on the basis of not knowing that this was a hanging and that resuscitation was being carried out. There may also have been some misunderstanding on the part of EMAS as to what having medics on the scene meant and the level of expertise and equipment that was available to them.”

227. The second call to EMAS was made at 5.36pm. In this call it was clearly stated that the problem was a hanging and the call response was upgraded at that point to red. The paramedic arrived at 5.48pm. A quicker response from EMAS would have occurred if the ambulance had been called as soon as the woman was found and the initial 999 call had included more complete information about her condition. I endorse the clinical reviewer’s two recommendations, slightly recast:

**The Governor should ensure that only appropriately trained operational support grades make calls for the emergency services, following contingency plans.**

**The Governor consults EMAS during contingency planning to improve understanding between the agencies as to how they both work.**

I add a further recommendation:

**The Governor should ensure that the local contingency plan clearly specifies who should request an ambulance, as per PSO 2710.**

#### **Next-of-kin details**

228. Prison records listed the woman’s next of kin as her mother, with whom she had apparently not had contact for 13 years. This caused some doubt when she died as to whom to treat as her next of kin and some distress for her husband who was not immediately contacted by the prison. The woman had married at Foston Hall in 2003, so it seems appropriate that at least at this stage her next of kin details should have been reviewed. I make the following recommendation:

**The Governor should ensure that prisoners’ next of kin details are reviewed on an annual basis and when a prisoner’s personal circumstances change.**

#### **Prisoners returning from outpatient appointments**

229. When the woman attended dermatology appointments at an outside hospital she was consistently seen by a member of healthcare on her return to the prison to ascertain the details of her appointment, any new prescriptions, and any action the prison would need to take in the future. This ensured that the prison was kept well informed, since they were not provided with any

immediate information directly from the hospital. I endorse the clinical reviewers' view that this was good practice.

**Healthcare staff reviewing prisoners immediately on their return to prison from outpatient appointments is good practice.**

### **Family liaison**

230. The incorrect next of kin details were amended quickly and the family liaison which followed was of an excellent standard. Both the woman's son, his guardian and her husband were kept up to date as information became available. They were given plenty of opportunity to ask questions, and the family liaison officer remained in touch until around six months after the woman's death when he transferred to another establishment.
231. The family liaison officer who then assumed the role was sensitive in contacting both the woman's son and husband around the first anniversary of her death. This seems to have been much appreciated by the family.

**The family liaison work was of a high standard and every effort was made to keep the family well informed and involved in the decision making process, while also checking on their wellbeing.**

## CONCLUSION

232. The woman had been in prison for over 12 years at the time of her death. During this time, she had made considerable progress in addressing issues relating to her offending and was working hard to be approved for open conditions by the Parole Board. She was a well-liked prisoner, but one who was also often described as being very private. This sometimes made it hard for staff to assist her with problems that were upsetting her. She had not been considered a suicide risk since 2000 and, during her time at Foston Hall, no concerns were ever raised in this regard by staff. My investigators have seen nothing which indicates to the contrary.
233. Several members of staff did try to help her and it seems she enjoyed working in the sanctuary immensely. However, I conclude that more could have been done to challenge the relationship between her and Prisoner A, which appears to have been very volatile in nature. She disclosed to one member of staff that Prisoner A was violent towards her. This does not seem to have been investigated as per the violence reduction policy and I make a recommendation in this regard, along with one regarding more thorough recording and sharing of information.
234. In consideration of the emergency response, staff should be proud of their determined efforts to save the woman's life. However, it seems some of the policies, including who can make a request for an ambulance and the detail of initial emergency call, could be clarified to avoid unnecessary delays. However, I do not think it would have made any difference in the woman's case.

## RECOMMENDATIONS

1. The Governor should ensure that staff are clear when and how to challenge relationships between prisoners, particularly when it is evident that there is friction.

*This recommendation was accepted. The Safer Custody Policy and Decency Policy will both be reviewed and updated to ensure that staff are clear of their role in respect of apparent relationships between prisoners.*

2. The Governor should remind staff that contemporaneous records should be kept on P-NOMIS with regard to prisoners' concerns and decisions affecting them.

*This recommendation was accepted. Staff will be reminded about the appropriate use of P-NOMIS in maintaining contemporaneous records.*

3. The Governor should remind staff of the contents of the violence reduction strategy policy including the need to report, record and communicate all incidents of violence and act on these as appropriate.

*This recommendation was accepted. Staff will be reminded of the Violence Reduction Strategy Policy and the actions required within that document. Violence Reduction Coordinator to develop and implement a series of awareness events and sessions.*

4. The Governor should consider implementing a code system to notify medical staff about the nature of an emergency to enable them to take the right equipment to each situation.

*This recommendation was accepted. A system has been implemented for Medical Emergency Response Codes: RED – Large blood loss to individual(s) and BLUE – Breathing difficulties, Ligation/hanging/self- strangulation, Anaphylaxis. Pocket sized aide memoir cards have been issued to all staff.*

5. The Governor should consider ensuring that all prison staff receive CPR training, such as Heartstart, on an annual basis.

*This recommendation was accepted. A rolling training programme is in place, which includes Heartstart. As at 11 May 2010 36% trained. A concerted push will be made to ensure all staff are trained by 31 December 2010. Staff are refresher trained on an annual basis.*

6. The Governor should ensure that only appropriately trained operational support grades make calls for the emergency services, following contingency plans.

*This recommendation was accepted. Operational Support Grades will be briefed and the Contingency Plans updated to include the fact that only appropriately trained OSGs make calls for the emergency services. A review will be conducted to ensure that all OSGs detailed to work in the Communications Room are appropriately trained.*

7. The Governor consults EMAS during contingency planning to improve understanding between the agencies as to how they both work.

*This recommendation was accepted. A review of the EMAS protocol will take place including ensuring that a line of communication is in place between the two agencies to improve understanding as to how they both work.*

8. The Governor should ensure that the local contingency plan clearly specifies who should request an ambulance, as per PSO 2710.

*This recommendation was accepted. Operational Support Grades will be briefed and the Contingency Plans updated to include the fact that only appropriately trained Communications Room staff make calls for the emergency services, as per PSO 2710.*

9. The Governor should ensure that prisoners' next of kin details are reviewed on an annual basis and when a prisoner's personal circumstances change.

*This recommendation was partially accepted. Prisoners' next of kin details will be confirmed on reception and an annual update will be coordinated via the Safer Custody Manager, however, we will be unable to confirm the accuracy of the information provided as it is self-report from the prisoner.*

## **GOOD PRACTICE**

1. Healthcare staff reviewing prisoners immediately on their return to prison from outpatient appointments is good practice.
2. The family liaison work was of a high standard and every effort was made to keep the family well informed and involved in the decision making process, while also checking on their wellbeing.

## FAMILY RESPONSE

1. This report was sent to the woman's son, via his legal guardians, who did not offer any comment prior to the publication of the final report. It was also sent to the woman's husband and I thank him for his comprehensive response in which he expressed continuing concerns on the matters below:
  - Police Investigation
  - The woman's relationship with Prisoner A and the failure of staff to act on the non adherence to the decency policy
  - The Governor's knowledge regarding this relationship
  - Significance of tramadol
  - Family liaison
2. The woman's husband did not believe that the police investigated his wife's death. As is routine procedure, the cell was classed as a crime scene until the police conducted their investigation and were satisfied that there were no suspicious circumstances.
3. In his response to the draft report, the woman's husband is particularly frustrated about staff's lack of action in intervening in the relationship between her and Prisoner A. He does not believe the investigation goes far enough in attributing blame to these members of staff. The first three recommendations in the report centred on this issue. He also believes that the Governor who was head of residence did know about the woman and Prisoner A's relationship before he allowed Prisoner A to move to the same wing as her in January 2009. I have reflected my thoughts on the amount of time which lapsed between the Governor's (who was head of residence) meetings with staff concerning the woman. In addition staff did not tell him they had any concerns about Prisoner A's moving wing in January 2009.
4. The woman's husband also questioned whether she had ever requested a tramadol prescription from a medical professional. I told him that I have not seen any evidence to suggest that he did. He was also unclear regarding the cause of death and how tramadol could be reported to be in the "lethal range" but neither contribute to, nor cause the woman's death. I have explained my understanding of this conclusion to her husband.
5. Lastly, in his response to the investigation, the woman's husband says that he was dissatisfied with the family liaison provided by Foston Hall. He felt he was treated differently and insensitively by staff because he was a serving prisoner. I told the woman's husband that my conclusion was that the decisions staff made were largely reasonable and I found no evidence he was treated differently due to him being in prison.