

A Report by the  
Prisons and  
Probation  
Ombudsman  
Nigel Newcomen CBE

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**Investigation into the death of a woman at  
HMP Foston Hall in December 2012**

## ***Our Vision***

*'To be a leading, independent investigatory body,  
a model to others, that makes a significant contribution to  
safer, fairer custody and offender supervision'*

This is the report of the investigation into the death of a woman at HMP Foston Hall in December 2012. She was 51 years old. She was found on the floor of her cell with a ligature around her neck. I offer my condolences to the woman's family and friends.

The investigation was carried out by one of my investigators. A doctor appointed by Derbyshire County Primary Care Trust carried out a review of the clinical care the woman received at Foston Hall. The prison cooperated fully with the investigation.

The woman was reported to be an outgoing person, but those who knew her well recognised her vulnerabilities. She sometimes spoke about wanting to kill herself and, at times, deliberately harmed herself. She had been monitored under suicide prevention procedures many times during her nine years in prison, but most of those who knew her did not really believe that she wished to die. She described her past suicide attempts as impulsive, but there was always a risk that she would succeed one day.

Some of the woman's concerns centred on her physical and mental health. She had frequent contact with healthcare staff who tried to address her physical health problems. She also received counselling and was seen by a psychiatrist. She was prescribed anti-depressant medication, but healthcare professionals did not believe she was suffering from a serious mental illness. Overall, the clinical reviewer concludes that the healthcare the woman received was equivalent to community standards.

The woman had complained that she was being bullied by other prisoners at Foston Hall. These allegations were not dealt with appropriately but we have found no evidence that bullying or any other particular event triggered her actions on the night of her death. She was monitored under suicide prevention procedures until four days before her death, when staff felt that her mood had improved and her problems had been resolved. Although there was no clear evidence to indicate that her risk of suicide had risen in the days leading to her death, or that her death could reasonably have been prevented, the investigation concludes that the decision to end the monitoring was inappropriate. While this is unlikely to have effected the outcome for the woman, I am not satisfied that suicide and self-harm prevention procedures were effectively managed at Foston Hall.

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

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

**August 2013**

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## SUMMARY

1. The woman was remanded into custody in 2004, charged with murder. It was her first time in prison. She was convicted in 2005 and was given a mandatory life sentence, with a minimum of 20 years to serve. She had a history of mental health issues, including anxiety and post-natal depression. She also had physical health problems which included deep vein thrombosis and chest pain. At HMP New Hall, she was prescribed anti-depressants and blood thinning medication. In the early years of her sentence, she sometimes harmed herself by various means.
2. In November 2011, the woman transferred to Foston Hall. A month after her arrival she was re-prescribed anti-depressant medication. In 2012, she was referred to the mental health team and talked about her suicidal thoughts and traumatic past experiences. She was given an appointment with a consultant psychiatrist, who did not think she had any serious mental illnesses, but decided to review her over time. Her anti-depressant dose was raised because she said she still felt depressed. She was also referred for counselling.
3. In February 2012, the woman said she was being bullied by prisoners on her wing and so she moved to F wing in March. She worked in the prison kitchen and said that she loved her job. She was known for her singing and was generally seen as bubbly and loud. Despite this, some staff believed she was vulnerable and fragile with complex needs. She had a partner in the community, and the relationship clearly meant a great deal to her. Her mood was closely linked with the state of the relationship. She was sometimes monitored under suicide prevention measures because she said that she thought about suicide and would not be able to go on living if anything happened to her partner.
4. In August and September 2012, the woman's physical health deteriorated. She was checked frequently by healthcare staff who found she had high blood pressure but no other serious health problems. She said that she was not eating properly, perhaps because she was trying to lose weight. She also stopped taking her medication properly. She was briefly monitored again under suicide prevention measures.
5. At the end of October, she was monitored again under suicide prevention measures when a nurse suspected that she had been harming herself. The woman said that she had tried to hang herself a few weeks earlier. The monitoring ended two weeks later when staff thought that her mood had improved and she said she had no thoughts of self-harm.
6. In October and November, there was growing evidence that the woman was being bullied by a prisoner on F wing. However, the matter was not properly investigated and no further action was taken to deal with the alleged perpetrator or offer formal support to her. She again stopped eating properly and taking her medication. On 24 November, suicide monitoring procedures were started again. She was concerned about her mail being withheld from her, her relationship with her offender supervisor and her relationship with her partner. By the end of the month, she was apparently eating and taking her

medication. Although suicide monitoring procedures continued, staff did not think that she posed a high risk of self-harm or suicide.

7. On 6 December, the safer custody manager decided to end the suicide monitoring procedures, although not all of the woman's problems had been resolved. Staff and her friends thought she seemed in good spirits and that her mood had improved. Although she seemed to be having some problems with her partner, there were no clear indications that she was thinking of harming herself. Over the weekend shortly before her death, she participated in a wing karaoke session and helped to decorate the Christmas tree.
8. The woman was checked at 9.00pm on an evening in December, when she spoke to staff and appeared to be fine. The next time staff checked, at 3.00am the following morning, they could not see into her cell and she did not respond to their calls so they went in. She was found on the floor of her cell with a ligature around her neck. Staff attempted to resuscitate her, although there were signs that she had been dead for some time. Paramedics attended and, at 4.10am, confirmed her death.
9. We have concerns about how suicide monitoring and violence reduction procedures were managed at Foston Hall and have made recommendations for improvements. While we conclude that, generally, the woman received adequate mental and physical healthcare at Foston Hall, we have also made recommendations regarding mental health provision. We make eight recommendations in total.

## THE INVESTIGATION PROCESS

10. The Ombudsman's office was informed of the woman's death on 10 December 2012. The investigator issued notices to staff and prisoners at HMP Foston Hall to inform them of the investigation and asking anyone with relevant information to contact her. One prisoner did so and was interviewed.
11. On 14 December, the investigator visited HMP Foston Hall and met the Governor, the prison family liaison officer, the head of healthcare and other staff. She also met a member of the Independent Monitoring Board (IMB) and a representative of the POA (the prison officers' union). The investigator obtained copies of the woman's prison and medical records.
12. Derbyshire County Primary Care Trust (PCT) appointed a clinical reviewer to review the clinical care the woman received at Foston Hall. The clinical reviewer and the investigator had sight of an internal investigation carried out by the mental health team.
13. The investigator and the clinical reviewer interviewed staff and prisoners at Foston Hall in February and March 2013. The Governor was given verbal and written feedback after the interviews.
14. HM Coroner for Derby and South Derbyshire was informed of the investigation and provided the results of the post-mortem report. The Coroner has been sent a copy of this investigation report.
15. One of the Ombudsman's family liaison officers contacted members of the woman's family outlining the purpose of the investigation. In April, she and the investigator visited one member of the family. The woman's family identified a number of concerns and questions, summarised as follows:
  - They told us she had complained of bullying by other prisoners and prison officers at Foston Hall during telephone calls to them. They asked if staff were aware of this and, if so, what action was taken to support their relative?
  - She had written to her family in the months before her death telling them that she had attempted to harm herself. Her family wanted to know whether she was being monitored under suicide prevention measures at the time of her death and if so, whether the monitoring was appropriate. They asked why items she could use to harm herself had not been removed from her room and why she was not being constantly monitored at the time of her death.
  - When the woman's family viewed her body at the mortuary, they noticed that she had a black eye. They were concerned that this was evidence that she had been assaulted before her death. The woman's family felt that her apparent suicide was triggered by an event that occurred in the days leading to her death as, in their view, she was not the type of person to do this without something significant taking place.
  - Whether she was receiving appropriate mental and physical healthcare at Foston Hall, whether she was prescribed any medications and why?
  - Whether the staff response when she was discovered was appropriate and whether there was any delay in calling an ambulance and one arriving.

- The woman's family asked a number of questions about her access to clothing, hygiene products and her participation in prison activities. We have addressed these matters, which we do not consider were directly related to the circumstances of her death, in a letter.
16. The final version of our report includes the National Offender Management Service's (NOMS) response to the recommendations made. We are very grateful to the woman's family for considering the report at the draft stage. They remain concerned about aspects of the care afforded to their relative at Foston Hall. Their comments have not resulted in changes to the report and have been addressed in separate correspondence.

## **HMP FOSTON HALL**

17. HMP Foston Hall, Derbyshire is a prison for adult remanded and sentenced women. It can hold up to 310 prisoners.
18. Derbyshire Health United is commissioned to provide the primary health services at Foston Hall, including nurses, doctors and a counsellor. The doctors are available for three and a half hours each week day but nurses provide healthcare cover 24 hours a day. Two clinic sessions each week are provided by psychiatrists, and prisoners with mental health problems can also be referred to a visiting forensic psychologist or occupational therapist.

## **Her Majesty's Inspectorate of Prisons**

19. HM Inspectorate of Prisons (HMIP) last carried out a full inspection at Foston Hall in September – October 2009. During that inspection, inspectors found that bullying was not a major problem at the prison and that any identified incidents were thoroughly investigated and alleged perpetrators were suitably monitored.
20. The self harm and suicide monitoring procedures (ACCT - Assessment, care in custody and teamwork, explained later) required some improvement. The Inspectorate found that staff from healthcare, counselling and other areas in the prison were insufficiently involved in the ACCT process and reviews were not sufficiently multi-disciplinary. Case management was identified as inconsistent and few care plans reflected issues that had been identified in assessments or case reviews. Not enough staff had attended ACCT refresher training.
21. In November 2012, HMIP carried out a short unannounced follow-up inspection to check the prison's progress against the recommendations made after the 2009 inspection. HMIP found that there was still a low level of violence in the prison and that the management of violence reduction processes was reasonable. However, insufficient numbers of staff had received violence reduction training.
22. ACCT processes were still underdeveloped and the overall quality of ACCT case management was insufficient. A 2009 recommendation that ACCT procedures be improved and include more consistent case management and involve a range of disciplines had not been achieved by 2012. The recommendation that more staff undergo ACCT refresher training had also not been achieved. Health services were found to have improved.

## **Independent Monitoring Board**

23. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who monitor all aspects of prison life to help ensure that proper standards of care and decency are maintained. The most recent IMB annual report for Foston Hall covers the year to November 2012.
24. The IMB raised concerns that new procedures had led to significant delays in the distribution of prisoners' mail which had adversely impacted on prisoners'

abilities to maintain family ties. The IMB also commented that prisoners reported high levels of bullying and some unfair treatment by staff.

### **Previous deaths at HMP Foston Hall**

25. This woman is the third prisoner to take her life at Foston Hall since 2004, when the Ombudsman began investigating all deaths in custody. In 2009, we made a recommendation about ensuring that incidents of violence or bullying were dealt with in line with the prison's violence reduction policy.

### **Assessment, Care in Custody and Teamwork (ACCT)**

26. ACCT, the Prison Service process for supporting and monitoring those prisoners thought to be at risk of harming themselves, was introduced in 2007. An ACCT plan can be opened by anyone working in the prison if they have any concerns that a prisoner might have tried, or, in the future, might try to harm himself. The purpose of ACCT is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Levels of observations (where staff must check the prisoner) and interactions (where staff must have a conversation with the prisoner) are flexible and can be set according to the perceived risk of harm. If staff perceive the risk of harm to be very high, the prisoner may be constantly observed, with a member of staff positioned outside their cell at all times. Where the perceived risk is lower, the level of observations may be several times an hour or day. Observations also take place during the night.
27. Part of the ACCT process involves drawing up a caremap. A good caremap will identify the prisoner's most urgent and pressing issues, set achievable goals to help resolve the issues and identify who is responsible for resolving each goal. The ACCT plan should not be closed until all of the actions on the caremap have been completed. Once the ACCT has been closed, a post-closure review should take place (normally within two of weeks of the ACCT closure). The purpose of the post-closure review is to check whether the prisoner has any remaining issues requiring support or resolution and that it is appropriate for the ACCT to remain closed.

## KEY EVENTS

28. In September 2004, the woman was remanded into the custody of HMP New Hall, charged with murder. She was 43 years old, had never been in prison before and had a lengthy and complex medical history including deep vein thrombosis (when a blood clot forms in the vein) and chest pain. In 2004, she had been diagnosed with rheumatoid arthritis. She also had a number of mental health problems. In 1983, she had been diagnosed with a manipulative personality. She also had a history of post-natal depression and anxiety. After her remand into custody, she reportedly attempted to harm herself a number of times, including by cutting herself and trying to suffocate and hang herself.
29. The woman was convicted in December 2005, and received a mandatory life sentence, with a minimum of 20 years to serve. Several other members of her family were also imprisoned in relation to the murder. The woman's prison record shows that she continued to harm herself after receiving the sentence.
30. In October 2007, doctors at New Hall prescribed the woman warfarin to help thin her blood and avoid blood clots. Once prescribed warfarin, patients need regular tests to ensure the dose level is correct. The woman's blood was tested regularly throughout her time in prison.
31. The woman repeated being depressed in November 2009, and said that she had begun to harm herself again. She was prescribed citalopram (an anti-depressant). The following year, the woman said that she had thought about suicide and she was referred to the prison mental health team. In July 2010, she was prescribed mirtazapine (another anti-depressant) instead of citalopram. At times, she was monitored under ACCT procedures and in October 2011, her mirtazapine dose was raised because she said she was not coping. In early November, the doctor raised the dose again to 45 mg because she was tearful and low in mood and said that she was considering suicide. It appears that the prescription ended before she transferred to Foston Hall, although no reason for this is given in the medical record.
32. On 21 November 2011, the woman transferred from New Hall to Foston Hall and told staff that she had been bullied at New Hall. She also said that she had attempted suicide once before by taking an overdose of medication and had harmed herself on several occasions in the last five years. She said that she was not thinking of harming herself but, a month later, she said that her depression had returned and she was prescribed 15 mg of mirtazapine. She was not placed on ACCT plan at this point.
33. Shortly after arriving at Foston Hall, the woman got a job working in the prison kitchen. By all accounts she enjoyed the job and said she much preferred to be busy. Officers and her friends said that she often volunteered for extra shifts. Her friends described her as a generally happy woman, who was always singing. Initially, she was given a single cell on B wing.
34. On 21 February 2012, another prisoner and violence reduction representative told staff that the woman was being bullied by a prisoner on E wing. The fellow prisoner spoke to staff who completed a Security Information Report

(SIR). (An SIR must be submitted by any one working in a prison who has information which might compromise the safety of the public, prison staff or other prisoners, or the security of the prison. SIRs are dealt with by the prison's security department.) The next day, the woman and fellow prisoner/violence reduction representative spoke to staff again. The woman was tearful and said that the prisoner had called her a 'grass' (a prisoner term for an informer). She said that she had had enough and that she and her friend wanted to move to another wing. The information was recorded on a second SIR, but staff wrote that they suspected that the woman was trying to manipulate them so she could move to a wing of her choice.

35. On 29 February, the woman again complained that she was being bullied and the information was submitted on another SIR. Despite a total of three SIRs being submitted about potential bullying, there is no evidence to suggest that the allegations were investigated under the prison's violence reduction policy. However, on 1 March, she and her friend moved to F wing. No specific reasons for the move were recorded in the woman's file.
36. The violence reduction coordinator at the time of the woman's death was interviewed about the violence reduction policy. She explained that any member of staff could open a violence and anti-social behaviour investigation if there was any evidence of anti-social behaviour, including if a prisoner said that she felt intimidated or vulnerable. Staff opening the investigation were expected to speak to the prisoner complaining of anti-social behaviour, gather information about the nature of the problem and the prisoners involved and collect statements. The investigation would then be passed to a senior officer and then a governor for review and a decision about what action should be taken. Part of the investigation documentation included a check sheet to confirm that relevant departments had been informed about the outcome. The violence reduction coordinator said that anti-social behaviour problems were discussed at a weekly safeguarding meeting, attended by a range of disciplines, including healthcare staff. She said that details about the results of investigations should be entered on the prison's electronic system, P-NOMIS, which all staff in the prison could access.
37. The violence reduction coordinator said that staff were not formally trained in the operation of the policy but that information about how to deal with anti-social behaviour was available to all staff on the prison computer system. She said they could also seek advice from her or other managers.
38. On 24 April, the woman complained again she was being bullied, by different prisoners. Again the information was submitted on an SIR and staff recorded that they had asked her to write down details of the bullying so that they could investigate further. There is no record that she provided written information about the bullying or that staff investigated her claims any further. She was briefly monitored on an ACCT plan on two occasions in April 2012 when she said she felt depressed and was thinking of harming herself.
39. On 10 July, the woman attended a routine appointment with healthcare staff. She became upset talking about events from her past and she was referred to the mental health team.

40. A nurse from the mental health team assessed the woman on 26 July. The woman told her that she felt low and often thought about self-harm and suicide. She described wanting to punish herself for abuse she had suffered in the past. The nurse recorded that the woman had been the victim of verbal, sexual and physical abuse during her marriage. The woman said that she had tried to kill herself numerous times, including trying to suffocate or drown herself, taking an overdose and cutting her wrists. She said that she spent time thinking of ways to kill herself and that although each attempt had been an impulsive act, at the time, she had wanted to die. She told the nurse that her relationship with her partner helped her but that he was in hospital, and that if he died, she would have nothing left to live for.
41. The nurse from the mental health team recorded that the woman was prescribed 15 mg of mirtazapine, but that it was not helping. The woman said that she had lost two stones in six weeks because she did not feel hungry. She also described feeling restless and agitated. She said that when something was troubling her, she put on loud music and sang and “put on a front” so that others would not know she was upset. She rated her mood as two out of ten and described suffering with low self-esteem. She said that she went to the prison gym every night for as long as possible to try and drain her energy, but that she found it difficult to sleep. The nurse recorded that the woman was not experiencing any thought disorder or delusions (which can be signs of a serious mental illness) but assessed her as having severe suicidal thoughts, mild thoughts of other self-harm, a mild eating disorder and mild over-activity. She decided that the woman should be discussed at the next multi-disciplinary meeting, that her medication needed to be reviewed and that she should be referred to the consultant psychiatrist for further assessment. Despite recording that she had severe suicidal thoughts, the nurse did not open an ACCT plan.
42. The woman had an appointment with the consultant psychiatrist on 8 August. The psychiatrist noted that she had experienced a difficult upbringing, and that her father had suffered paranoia and schizophrenia. The woman said that she had not been in contact with mental health services before. She said that she sometimes felt depressed but was engaged to her partner, who she felt very positive about. The psychiatrist concluded that the mirtazapine dose should be raised to 30 mg, to be taken at night, and that the woman might benefit from counselling. According to the medical record, the mirtazapine dose was increased on 17 August.
43. The consultant psychiatrist told the investigator that, in his view, the woman did not have a significant mental illness but probably had some form of personality disorder, with an associated mood disorder. He explained that his prison clinic appointments are only 20 minutes long, which can make it difficult to form a clear diagnosis. Because she had expressed suicidal thoughts, and was already prescribed anti-depressants, he decided to see her again for further review. He said that, at their first meeting, he did not think that she was at high risk of suicide. His view was that her mental health needs would have been met by primary care services, such as her doctor or perhaps by referral to a psychological therapy such as counselling had she not been in prison. He did not think she would have been under the care of a psychiatrist had she been living in the community.

44. The woman attended a counselling assessment appointment on 14 August with the counsellor and was placed on the waiting list. She did not attend her first appointment on 3 September (we do not know why), and another planned for 24 September had to be rearranged. The first appointment took place on 1 October.
45. On 19 August, the woman complained of chest pains. She was assessed by a nurse, who took her blood pressure reading as 170/110 which was high. The nurse did not think that she was suffering a serious medical problem and prescribed an indigestion aid. The next day, she collapsed on the wing. A nurse assessed her again and noted that her pulse, blood pressure and other observations were within normal limits. She was advised to rest. The nurse noted that the woman had a number of unexplained small bruises on her arms and legs.
46. On 22 August, the woman was examined by the on call doctor after she complained of a crushing pain in her left side and collapsed. The doctor recorded that she was sweaty and complaining of being short of breath. Her blood pressure was 148/98 (higher than normal) but her chest sounded clear. The doctor decided that she should be taken to the accident and emergency unit at the local hospital. At hospital, the woman had a number of tests including an electrocardiogram (ECG) which indicated that her heart was functioning normally. Hospital staff concluded that she might be suffering some kind of problem with her digestive system and they suggested a possible referral to the hospital department specialising in the oesophagus, stomach and intestines. She went back to the prison later the same day.
47. On 10 September, staff became concerned about the woman's physical health again. A prison doctor examined her and noted that the hospital had suggested a referral. The doctor directed that the woman's weight be monitored for a period of time before any referral was made. We have found no evidence that this happened. Over the following fortnight, healthcare staff examined her several times because she either complained of feeling unwell or officers were concerned about her. She admitted that she was not eating very much and was reminded that she needed to eat a healthy, balanced diet. Around 17 September, she stopped collecting her medication, including her warfarin. When asked about this, she said she had been feeling too unwell to collect it. A prison doctor examined her on 17 September, diagnosed high blood pressure and prescribed ramipril, to treat this.
48. Over the next few days, the woman was seen often by healthcare staff. She collapsed more than once and it seemed that she was eating very little, possibly in an attempt to lose weight. Officers and her friends said that she had a very negative body image. She used the gym as often as she could and some interviewees thought she had stopped eating properly to help lose weight quickly, rather than because she was ill. On 24 September, she saw a prison doctor who recorded that other than high blood pressure, the woman had no other diagnosable health problems.
49. At 8.10pm that evening, the woman was placed on an ACCT plan because she told staff that she would kill herself if her partner (who she said was about to have an operation) died. She said that she had made a plan and had rehearsed it in her head three times. A senior officer (SO) completed the

immediate action plan, directing that she be constantly supervised until the ACCT assessment had taken place.

50. An officer carried out the ACCT assessment at 9.00pm. The woman repeated that she planned to kill herself if her partner died during heart surgery, due to take place on 1 October. She said that she had been feeling physically unwell for two weeks, was not eating and felt tearful and low. She said she felt very lonely and would not be able to cope if her partner died. The officer wrote that the woman's only focus was her partner and that she was "besotted" with him. The officer wrote that the woman had a number of friends on the wing, but that she could not think about anything but her partner. The woman, who had served nine years of her sentence at this point, said that she had had enough of prison.
51. The officer who carried out the ACCT assessment who was based on F wing and knew the woman quite well, thought that the woman had a good relationship with wing staff and said that she often came to the wing office to offer to help with tasks around the wing and to chat. The officer said that the woman often sent cards to staff thanking them for their support. She described the woman as very open and honest. She thought that most of her issues centred on her relationship with her partner, whom she seemed quite obsessed with.
52. Although the woman told the officer she had made a plan to kill herself, she would not discuss the plan any further. The officer said that staff were worried because she was not eating properly and not taking her medication as prescribed. The officer said that she was worried that if the woman's partner's health deteriorated, she would pose a high risk to herself.
53. The first ACCT review was held at 11.50am on 25 September. A senior officer chaired the review, and an officer from F wing and the woman were also there. The officer who had carried out the ACCT assessment was not at the review, but according to the ACCT plan, spoke to the SO that chaired it beforehand. (At interview, she could not remember having had a conversation with the SO before he chaired the case review.)
54. The woman said she had no plans or intention to kill herself but repeated that her partner was due to have a serious operation on 1 October. The SO chairing the ACCT review wrote that the woman had a good support network (although he did not specify what this was) and that the Governor had agreed that staff could seek regular updates on her partner's condition while he was in hospital. The officers judged her risk of self-harm to be low. They made no entries in the caremap and concluded that the ACCT could be closed. A post-closure review was scheduled for 2 October, but did not take place until 14 October. No entry was made in the wing observation book after the case review to alert staff to her partner's operation, however another member of staff noted the information on 26 September, after a conversation with the woman. The officer who had carried out the ACCT assessment said that she was not aware the ACCT plan had been closed so quickly and that, if she had been asked for her view, she would have recommended that it remained open.

55. On 1 October, the woman had her first counselling appointment with her counsellor. The counsellor told the investigator that she explained that she normally offered prisoners eight counselling sessions with one session each week, but that they could have more if she and the prisoner agreed it was necessary. The counsellor said that, after the assessment appointment, she felt that the woman had very complex problems and would require a longer term intervention. She said that she assessed the woman's main needs to be around self-esteem, relationships and self-harm issues. She said that, although the woman gave the impression of being happy and bubbly, she considered her to be a fragile and vulnerable woman.
56. On 11 October, a nurse was called to see the woman in her room because she had collapsed. She told the nurse that she felt dizzy. The nurse recorded that she looked unwell, seemed to have lost weight and was covered in bruises, except on her back. Healthcare staff thought that one explanation was that she was inflicting the bruises on herself. She told the nurse that she thought she had an autoimmune disease (one of the symptoms of which can be bruising). The nurse noted that the woman had told other prisoners that she had cancer, which was not the case. The nurse arranged for her to have a blood test and be weighed, however, she did not come to the appointment the next day despite being called twice. On 11 October, due to her physical health complaints, she moved to a cell on the ground floor of F wing so that she did not have to climb stairs.
57. The nurse and a prison doctor discussed the woman on 12 October and agreed that her blood needed to be tested for clotting and her blood pressure and weight needed to be monitored. They agreed that an appointment would be arranged for the following Monday and that she would be advised that she must attend.
58. The ACCT post closure review was conducted by a senior officer on 14 October. The woman said that her partner had been discharged from hospital and so she was feeling much less worried about him. She said that she received support from friends and family, both in letters and telephone calls. She also said that she could talk to wing staff and had many friends on the wing. She told the SO that she enjoyed her work in the kitchen and got much satisfaction from it. She completed a post-closure questionnaire, and said that she felt supported by wing staff, who were caring and helpful, and could talk to them about any of her issues if she needed to. She wrote that she was not sure whether the issues that had led to the ACCT being opened were resolved as although her partner had been discharged from hospital, he sometimes upset her.
59. The woman attended her blood test appointment on 16 October and the results were normal.
60. On 17 October, the woman told officers that another prisoner on F wing (who we refer to as Ms A in this report) had asked her for some of her prescribed medication, which she had refused to give her. The officers recorded the information in an SIR and in the wing observation book. Later that day, she had another appointment with the consultant psychiatrist. She described feeling some improvements from the mirtazapine but said that she still felt low. He advised her to take the medication at night rather than in the

morning. She told the psychiatrist that she was being bullied on F wing and had told staff about this. She also complained of bruising on her body and the doctor noted that she should have another blood test because she was taking mirtazapine as well as warfarin. He arranged to review her in six weeks.

61. The consultant psychiatrist said that, although the woman said she had some thoughts of self-harm, he still did not think she was at high risk of suicide. Although this was not recorded in her medical record, he said that he would have asked the woman during the appointment about any suicidal plans she had made, how often she thought about self-harm or suicide and how she felt about past self-harm attempts. He did not think that she was significantly depressed and thought that her sessions with her counsellor might help. He said that he thought the woman sometimes expressed her emotional distress by raising concerns about her physical health, or by not taking her medication as prescribed.
62. A nurse made an entry in the woman's medical record on 17 October, noting that healthcare staff thought that the small bruises on her body might be caused by self-harm. She also recorded that the woman was not taking her medication correctly. (At the time, she was prescribed her medication to keep in her cell. She was given four weeks' supply and was expected to take the correct dose as prescribed by the doctors.) Because she was not taking her medication correctly, the pharmacist was informed and asked to collect the medication from the woman's cell. The nurse organised an appointment to discuss the concerns with the woman.
63. A pharmacy technician collected the medication from the woman's cell the next morning, 18 October. She noted that the woman had apparently taken one too many mirtazapine tablets, but insufficient doses of nefopam (a pain relief medication she had been prescribed for shoulder pain), bisacodyl (a laxative), ramipril and co-amilofruse (to treat water retention). The technician recorded that the woman would now be expected to collect her medication from the nurse each day.
64. Later that day, the nurse recorded that the woman had written to the healthcare department to say that she would not be attending any further appointments. She wrote that she had "done the right thing" and that healthcare staff were treating her as badly as "the bullies". She also said that she would not be collecting any medication, including warfarin, or have her blood tested. The nurse recorded that an appointment had been arranged for 22 October to try to discuss the issues with her.
65. On 19 October, another SIR was submitted, noting that the woman was telling people that her friends, wing officers and healthcare staff were "not bothered about her" and were treating her unkindly. She said that she would refuse all healthcare appointments and that, if her health deteriorated, it would be the fault of healthcare staff. Staff in the security department spoke to healthcare staff about the SIR and told them that a number of other SIRs had recently been submitted which suggested that she was trading her medication with other prisoners. At some point around this time, she contacted the IMB to complain she was being bullied by other prisoners for her medication and about healthcare staff's response. According to the IMB, when they contacted her about her complaint, she decided not to pursue the issue.

66. An SIR was submitted on 20 October, which noted that the woman had again complained that Ms A was pressuring her for her medication. The information was also logged in the wing observation book. Later an officer overheard the woman telling another prisoner that Ms A was taking items from her. The woman apparently told the prisoner that she was going to try and get moved to a different wing. The investigator asked to interview Ms A, but she refused.
67. The woman had a counselling appointment on 22 October and later, an appointment with a nurse. The nurse recorded that the woman was upset that she was no longer allowed to keep her medication in possession and she explained that this had been done to keep her and other prisoners safe. During the appointment, the woman complained of often feeling dizzy, light headed and generally run down. She said that her hair was falling out, her right leg was swollen and she had pain in her abdomen caused by irritable bowel syndrome and stress. They discussed healthcare staff's concerns about the nature of the bruises on her body. She strongly denied that she was harming herself and said that she did not know what was causing the bruises. She said that she had not taken any of her medication since 18 October and the nurse warned her of the consequences, but she said that she would not stand in the queue to collect medication. She said that she had also not eaten since 18 October but was drinking normally. Again, the nurse recorded that she had discussed the implications of this with the woman, who said that she did not care. She told the nurse that both her son and her partner had cancer and that she did not want to be left without them. The nurse checked the woman's blood pressure, which was 146/97 (slightly higher than normal).
68. The woman told the nurse that she was being bullied on the wing. She said that prisoners were calling her names and talking about her offence. She said that she would not report the bullying to officers for fear that she would be physically attacked. The nurse recorded that she would talk to officers on F wing about the bullying and would arrange for them to monitor the woman's food intake. She also arranged for her to see the doctor later that afternoon but she did not attend the appointment. The nurse did not open an ACCT plan.
69. The nurse told the investigator that she saw the woman often, either when dispensing medication or when she attended for her routine blood tests. The nurse said that the woman gave different reasons about why she was not taking her medication properly, including bullying. She said that when the woman complained of being bullied, she passed these concerns on to F wing staff. She said that she and healthcare staff generally took complaints of bullying very seriously, but as she would not give any names of prisoners who were bullying her, the options for staff to intervene were limited.
70. The nurse said that she, the prison doctor and other healthcare staff explained to the woman the consequences of not taking her medication. The nurse said that, over time, they tried different ways to encourage her to collect her medication including suggesting that she came to collect her medication early, or that it was prescribed in daily doses so that she only had to attend healthcare once a day. She rejected these suggestions.

71. On 24 October, healthcare staff noted that, since her appointment with the nurse on 22 October, the woman had been collecting her medication as prescribed.
72. The woman went to healthcare for a routine blood test appointment on 29 October. The nurse noticed what appeared to be recent self-harm marks on the woman's arms. At first, she denied that she had hurt herself, then said that she had done so the previous week and that wing officers knew about it. She told the nurse that she did not want to talk about it, but said that she had tried to hang herself on 1 October. She said the marks on her arms were the result of kitchen injuries. She told the nurse that she was not eating and only drinking one cup of soup a day.
73. The nurse told the woman that she would open an ACCT. She denied having a plan to kill herself but said that, if she wanted to harm herself, she would wait until after the observations had been carried out. At 2.08pm, the nurse opened an ACCT plan. She noted that the woman's triggers for self-harm were that both her son and her partner were ill, her poor body image and bullying issues on F wing. The nurse said that she was concerned that the woman posed a real risk to herself.
74. At 3.36pm, the woman had an appointment with a prison doctor. They discussed why she had not been taking her medication as prescribed or eating properly. She said that she had not been collecting her medication because she was no longer allowed to keep it in her cell, although she said that she understood why this was. She told the doctor that she was not eating because her partner was receiving chemotherapy. The doctor recorded that she was suffering an eating disorder. After her doctor's appointment, the woman also saw her counsellor for a counselling session.
75. On 30 October, an officer carried out the ACCT assessment interview. The woman said that she did not want to be on an ACCT and that she had self-harmed a couple of weeks earlier when her partner was in hospital and she had argued with him. She said that she had tried to hang herself a few weeks earlier, but had stopped herself. Although the self-harm marks on her wrists looked recent, she insisted that they were not.
76. The woman told the officer that she was expecting to be told that her partner had died. She said that, because of this, she felt low and found it difficult to eat. The officer noted that she was receiving counselling and input from the mental health team. The woman said that she was isolating herself on the wing but had no thoughts of harming herself. She said she was only thinking about her partner and he was the only thing that helped her to cope. She said that she enjoyed working in the kitchen, using the gym and being busy and viewed wing officers as her family. She told the officer that she was being bullied on F wing but was reluctant to provide written information about this. The officer wrote that the woman could seem loud on the wing, but was often hiding her true feelings behind this front.
77. The officer told the investigator that the woman was often vague about the bullying she reported and would not name any prisoners. However, the officer said that there was some information that Ms A was bullying her. The officer said that Ms A was moved off F wing and that she thought the bullying had

ended then. She said that any information about suspected or alleged bullying is recorded in the wing observation book so that all staff are aware and monitor prisoners appropriately. There are several entries in the wing observation book detailing the bullying allegations.

78. The ACCT case review was held at 11.50am that morning, chaired by a senior officer (SO). The officer who had earlier carried out the ACCT assessment review, the catering manager and the woman also attended. According to the ACCT plan, the woman was very talkative throughout the review and asked for the ACCT to be closed. She said that her partner had cancer and this was her main concern, but that she had lots of worries and was receiving counselling. The review group agreed that her risk of suicide or self-harm was low but that the ACCT plan should remain open. Staff were instructed to have at least two conversations with the woman a day, and also to offer her ongoing support. One entry was made on the caremap, noting that the woman's partner had cancer and that she was complaining of bullying on F wing. The action to be taken was recorded as staff support and counselling (which she was already receiving).
79. A second ACCT review was held on 5 November, chaired by the safer custody manager. The head of residence and the woman were also present. The safer custody manager recorded that the woman seemed fine during the review and was enjoying working in the kitchen. She said that when she was not working, she felt bored. He recorded that there had been a "small improvement overall" to the woman's demeanour. The review assessed her level of risk as still low and the frequency of conversations was unchanged. No further entries were made on the caremap and there is no evidence to indicate that the woman's concerns about her partner's health or bullying were discussed during the meeting.
80. The woman went to healthcare for a routine blood test on 6 November. She complained of bruises all over her body, which she said were caused by her medication. The nurse taking the blood sample advised her to make an appointment with the doctor. There is no evidence to indicate that she did so.
81. A senior officer (SO), an officer and the woman met for another ACCT case review on 12 November. The SO was the third person to chair the woman's ACCT case reviews. She recorded that they had reviewed her problems and the entry on the caremap, and had agreed that the ACCT should be closed. The woman said that she had no thoughts of suicide or self-harm and that she would speak to staff if her mood changed.
82. According to an entry in her medical record, the woman decided to stop taking her prescribed medication again on 12 November because, she said, her partner had stopped receiving chemotherapy. Healthcare staff noted that this would need to be discussed with the woman. It is not clear whether the staff at the ACCT review were aware of her decision to stop taking her medication, but it was not noted at the review. Despite her complex medical history and contact with the mental health team, no one from the mental health team or the healthcare department attended any of the woman's ACCT reviews. There is no evidence to suggest that any staff from other disciplines were invited to any of the woman's ACCT reviews.

83. The safer custody manager who had chaired the second ACCT review on 5 November (who has subsequently moved to another prison) said that multi-disciplinary ACCT reviews did take place at Foston Hall but that it could be difficult to arrange because of the time pressures on different departments. He said it was more common for prisoners on high levels of observations or who had been disruptive to have multi-disciplinary case reviews. A nurse said that healthcare staff were often invited to ACCT reviews, but that they could not always attend because of work pressures. She said that if no one could attend, verbal information would normally be submitted by telephone. However, the nurse said that, to the best of her recollection, she had never been asked to attend or provide information in relation to the woman's ACCT reviews.
84. On 13 November, another SIR was submitted suggesting that Ms A was bullying the woman for her canteen (supplies of foodstuffs, confectionery, toiletries and tobacco products that prisoners can buy to a limited value each week). The next day, an officer initiated an anti-social behaviour investigation. When interviewed, the officer said that he knew the woman quite well because he was an F wing officer. He said that she often came to the staff office to chat to officers and ask for support if she needed it. He knew that she had refused to take her medication for a while and that she sometimes did not eat properly. He said that when staff became aware of this they encouraged her to look after herself properly.
85. The officer said that the anti-social behaviour investigation was begun because another prisoner complained she was being bullied by Ms A and indicated that the woman was also being bullied by her. The officer spoke to the woman but said it was difficult to get any information from her. He presumed that other prisoners were taking advantage of her kindness. He said that Ms A had come to staff's attention before, as both the victim and perpetrator of bullying.
86. The safer custody manager carried out most of the investigation. His completed report indicated that he had spoken to all of the parties involved and was satisfied that Ms A had not bullied the other prisoner. He also wrote that he had asked the woman if she was being bullied and she had said she was not, although she was aware that some other prisoners were being bullied. He noted that she did not want to say who was being bullied.
87. However, as part of the investigation, the woman had provided a written statement in which she said that Ms A asked other prisoners for items from their canteen and had asked for her medication. She said that she had told an officer about this already. In the statement, the woman wrote that she did not know anything about alleged bullying by Ms A against the other prisoner because "...most days if I'm not in work, I sit in my room in the dark so I can let them think I'm not in." The safer custody officer concluded that no further action was necessary as there was no evidence of violence or anti-social behaviour. The residential governor signed off the investigation, noting that he agreed with the safer custody manager's assessment.
88. When asked about the contents of the statement during the interview, the safer custody officer said that the woman's statement did cause him some concern. He thought he had been given the statement before speaking to the

woman, although he could not remember whether this was definitely the case. The SO said he asked her if she was being bullied and she said she was not. It seems he did not discuss the contents of her statement with her. He said that, as part of an anti-social behaviour investigation, he could check SIR information for further evidence of concerns. In this case, he did not consider that any bullying had taken place so he did not pursue it further. He could not recall ever having been told that she was complaining of being bullied. However, not only were there a number of SIRs about the alleged bullying, there were also several entries in the F wing observation book about it.

89. At interview, the violence reduction coordinator said that she was aware of the growing number of SIRs noting that Ms A might be bullying the woman. She said that she had asked the safer custody officer (who was based on F wing) several times whether he had investigated the claims and he assured her that he was looking into the situation. She said that she was concerned by the contents of the woman's statement. She said that, in her view, the contents of the statement should have led to a separate anti-social behaviour investigation, focusing on the woman as the victim. She said that, if the woman had not wanted the investigation to take place, she should have been asked to sign a disclaimer to this effect.
90. The safer custody manager, an officer and the woman met on 15 November for the ACCT post-closure review. The officers agreed that the woman had made a steady improvement over the previous few weeks and that the issues that had led to the ACCT being opened had been resolved. They wrote that many of the woman's problems were relationship based and that her relationship with her partner had "calmed down". She said that she had no thoughts of suicide or self-harm. There is no record to suggest that bullying was discussed at all during the meeting.
91. A nurse spoke to the woman in the healthcare department on 16 November because she was refusing her routine blood test and to take her prescribed medication. The nurse wrote that the risks of refusing medical treatment had been explained to the woman, who was fully aware and adamant she would not accept treatment. The next day, she spoke to the woman again. She said that some other prisoners were hassling her for her medication and so she did not want to take it. The nurse explained the potential implications of refusing the medication and the woman agreed to begin taking it again.
92. On 24 November, a nurse spoke to the woman who was refusing food. The woman was vague about the amount of food she was consuming and for how long she had been refusing to eat. The nurse wrote in the medical record that she was also refusing to take her medication again. The woman said that she was collecting her meals but then flushing them down the toilet. She said that she had reached "the end of the line" and had had enough. The nurse spent time explaining the risks of refusing food and medication but noted that the woman was dismissive. The nurse checked the woman's blood pressure (which was 128/88 and slightly higher than normal) and pulse, which was normal. There were no signs that she was dehydrated.
93. As a result of their conversation, the nurse opened an ACCT plan at 4.30pm. She recorded that the possible triggers to the woman's self-harm were issues with her partner and son, not receiving her post and problems with her

offender supervisor. The nurse arranged for wing staff to monitor the woman's food intake.

94. The woman's offender supervisor told the investigator that he had been working with the woman since she arrived at Foston Hall and described her as a complex woman to work with. He believed that one of her main issues was her personal relationships with men. He said that he was concerned that she was writing to around 100 people, most of whom were male prisoners or inpatients at secure hospitals. He said that he tried discussing the issue with her and was concerned the relationships related to her risk of offending because, according to the woman, her involvement with men with pro-criminal attitudes had led her involvement in the murder for which she was convicted. Her offender supervisor said that he and other staff became concerned about the nature of some of her relationships with the men she was writing to. He was also concerned that some of the men she wrote to were vulnerable.
95. The woman's offender supervisor said that officers raised concerns with him about the amount of mail she was sending out and receiving each week, which they said was becoming unmanageable. Prisons normally monitor a small percentage of all post sent and received. Monitoring is generally random, unless there is information to suggest that a particular prisoner's post should be monitored. He said that he looked into the situation and found that Prison Service Instruction (PSI) 49/2011: Prisoner communication services, was not being properly implemented at Foston Hall.
96. PSI 49/2011 provides some guidance for prisons in managing prisoners' mail. One of the instruction's key outcomes is that prisoners can communicate with family and friends, however, prisons must also support security, order and public protection. The PSI notes that prisoners should be allowed to send as many letters as "practicable taking account of the staff resources available to examine and read correspondence". Prisoners' written correspondence with close family who are also in prison is unrestricted. They are also entitled to write to other prisoners with the approval of both Governors at the prisons involved. The PSI instructs that "approval should be given unless there are reasons to believe that such correspondence will seriously impede the rehabilitation of either prisoner" or where there are other reasons for preventing the two prisoners from communicating, such as public protection. If prisoners wish to write to people who have been released but are still on licence and reporting to an offender manager, the offender manager should give approval.
97. The woman's offender supervisor discussed the matter with other managers at the prison and, as a result, she was told that she could continue to write to ten people from her list. He said that she then identified 11 people, which he agreed to. He did not think that she had been particularly upset about having to restrict the number of people she could write to. He said that staff were concerned that some of her post posed a public protection issue because she was writing to convicted sex offenders about her children.
98. Discussion of the issue led to further changes at Foston Hall. In May 2012, a Notice to Prisoners was issued in relation to PSI 49/2011, explaining the terms of the PSI to prisoners. Prisoners were told that they would have to complete an application form in order to write to prisoners or ex-prisoners. On

18 June, another notice was issued clarifying that this did not apply to family members. On 22 June, a third notice informed prisoners that any letters to prisoners or ex-prisoners must now be accompanied by an application form or the post would be returned to the prisoner.

99. It seems that it took some time for the impact of the new procedures to affect the woman and other prisoners at Foston Hall. Certainly there is no evidence in her file to suggest that she complained about post before November 2012. An inmate at the prison told the investigator that many prisoners found the new procedures very confusing and that, for some time, there were severe delays to the sending and receipt of post. She said that the woman spoke to her as a diversity team representative and said that all of her post had been stopped. She said that the woman was devastated and felt she had been isolated from her support network. She felt she was being discriminated against, but her fellow prisoner reassured her that the policy was being applied to all prisoners at Foston Hall. The fellow prisoner said that it took several months for the new processes to be properly implemented and for post delays to be resolved.
100. At 11.00am on 25 November, an officer carried out an ACCT assessment interview after it had been opened by a nurse the day before. The woman said that she did not understand why the ACCT had been opened because she had not done anything wrong. She said that she had recently split up with her partner over drug issues but that her main issue was with her offender supervisor and access to her post. She said that she thought he was deliberately withholding mail from her, which meant that she was not getting support from her friends who wrote to her. She said that she had no one to support her and nothing to live for, and that she was refusing food and medication. She told the officer that she had attempted suicide by hanging in the past and that she did not enjoy being alive. She said that the letters she received helped her to deal with her issues. The officer recorded that the woman was very tearful and said she was finding it difficult to cope with the breakdown of her relationship. The officer wrote that the conversation revolved around her access to her post and that the woman felt she was being discriminated against. She said that she did not want to live but had not made any plans to kill herself, although she maintained that she would not eat. She said that she did not need to be on an ACCT.
101. Her offender supervisor denied that the woman was being treated any differently than other prisoners at Foston Hall, although her case was more extreme than some other prisoners. He said that he was aware she was unhappy with his role in the issue and had made complaints about access to her post. However, he said that she continued to attend appointments with him. He said that once she began submitting complaints naming him, he invited a senior officer (SO) to be present during their meetings.
102. Prisoners' telephone calls are routinely recorded so that they can be monitored if necessary and a proportion are listened to at random. There is evidence that, during random monitoring, staff listened to at least one of the woman's calls. As part of the investigation, we listened to her telephone conversations between 24 November and 9 December. On 24 November, she spoke to her partner. Although there were clearly some problems in the

relationship, and she said that she did not think they should get married, it appears that the relationship continued.

103. The first ACCT case review took place at 11.55am on 25 November. A senior officer (SO) chaired the meeting and two officers and the woman also attended. The SO wrote that the woman needed to talk to staff and that staff would monitor her food intake and check her regularly. The SO repeated the woman's concerns about access to her post and contact with her friends. The officers agreed that she posed a raised risk of self-harm or suicide. The observation level was set at once every two hours, and one recorded conversation each day. Two entries were made on the caremap, firstly that staff should continue to monitor her possible food and medication refusal and secondly, that she should interact with staff. Both entries on the caremap were marked as resolved by 6 December. (Interviews with officers and prisoners suggest that she had no problem interacting with staff.) There was nothing on the caremap relating to her concerns about contact with her friends.
104. Later that day, a nurse spoke to the woman. The woman said that she had not eaten or drunk anything since the previous afternoon. She said that she did not understand why healthcare staff were now worried about her, as they had not been concerned before. The nurse told her that was not the case and that healthcare staff wanted to help. The nurse took her blood pressure, which was recorded as 151/100 (higher than normal), and her pulse and blood oxygen levels which were within the normal ranges.
105. On 26 November, wing officers recorded that the woman did not collect her lunch and refused the evening's hot meal, although she took pudding and breakfast items. Over the following few days, she generally declined lunch but collected food in the evening. Wing officers interviewed during the investigation said that, while they can monitor whether prisoners collect food from the servery, they are not able to supervise prisoners if they choose to eat in their cells. While officers monitored whether the woman collected food or not, they could not say whether she was, in fact, eating anything.
106. A doctor and nurse met the woman on 27 November but she did not want to discuss her reasons for refusing medication and food, except to say that it was for personal reasons. However, she told the doctor that she and her partner had split up. She said she did not like the prison food, and although she worked in the kitchen, did not want to discuss this with the head of the kitchens. She also refused the offer of only collecting her medication once a day. The doctor explained that refusing food and medication was a form of self-harm, which the woman disputed. The doctor also explained that if she did not take her warfarin as prescribed, she was at risk of deep vein thrombosis, which could be fatal. The woman continued to say she would not take her medication.
107. Around 27 November, the woman submitted several confidential access complaint forms. Confidential access complaints are to allow prisoners to put serious matters directly to the prison Governor. The Governor explained that the majority of confidential access complaints were not appropriate for him to deal with and he referred them to the correct member of staff or department.

Confidential access complaints are opened by the Governor's secretary and logged on a database.

108. The woman wrote on one of the complaint forms that she was the victim of discrimination, harassment and victimisation, related to one of the legally protected characteristics (which include age, disability, gender, race, religion and sexual orientation). She did not specify which characteristic her complaint related to. In the complaint, she said that she had not received any mail for over five weeks, and had stopped eating or taking her medication. She wrote that she knew her life was at risk but that it was the fault of her offender supervisor and the offender management unit. She continued that, until she was treated the same as other prisoners, she would stop drinking fluids and that it would not be her who would be called to an inquest to explain. She wrote "see if he [presumably her offender supervisor] still has his smirk when doing all the paperwork for a death in custody". She wrote that she had attempted self-harm in the past because of "Foston Hall and [offender supervisor] and bullying, which you don't care about here". She accused the offender management unit of racism towards her.
109. The Governor said that, when he read the complaint, he did not think that the woman was threatening self-harm or suicide. He said that he was more concerned at her claim of racist treatment. He referred the complaint to the head of residence for action. He did not discuss the contents of the complaint with the head of residence and did not know when she was next on duty to deal with it. He said that he was unaware that she was on an ACCT plan and did not discuss the contents with anyone from F wing or the safer custody team. He said that, had he known she was on an ACCT, he would have referred the matter to the safer custody team. He did not think there was a central database listing which prisoners at Foston Hall were on an open ACCT. The safer custody manager told the investigator that such a database was available on a central folder on the prison computer system available to all staff. Other staff interviewed were also unaware of the database's existence. The Governor said that, in hindsight, he should have referred the complaint to the safer custody team, however, he believed he had dealt with the complaint in line with national policy.
110. The catering manager spoke to the woman at 11.15am on 28 November. She talked about her partner and said that she loved him, but thought he was involved in drug dealing. She said she did not want to be associated with him in that case.
111. At 3.25pm, the woman's personal officer talked to her about her food refusal. The officer encouraged her to eat that evening and she said it depended on what the evening meal was. Over the next two days, staff recorded that she sometimes collected food from the servery.
112. The woman had a routine sentence planning appointment with her offender supervisor and a senior officer on 29 November. The senior officer told the investigator that she thought the woman was making improvements and that they had made a breakthrough. She said that she talked about eating properly again and taking her medication. After the meeting, the woman wrote a letter to the senior officer and her offender supervisor. In many ways, the letter is positive and suggests that she had insight into her problems. She

wrote that she needed to hear people say they loved her, even if she knew it was not true. She wrote that she would think about what the SO and her offender supervisor had been saying to her and try to take on board their advice. However, at the end of the letter, she wrote that although she would “try harder”, she sometimes really felt like ending her life.

113. The senior officer could not recall exactly when she received the letter, but thought it might have been on 29 November. She thought she had read the letter before the woman’s death but said that she was not concerned by its contents. She knew the woman was on an ACCT and that staff were already monitoring her and she also did not think that she genuinely meant that she was contemplating suicide. However, she said that she rang F wing in any case, to check whether officers had any particular concerns about her. She said that she also discussed the contents of the letter with the woman’s offender supervisor.
114. Her offender supervisor agreed that the woman seemed in good spirits after their meeting on 29 November. He rang F wing after the appointment and officers told him that she had stayed out on the wing and appeared in a much happier mood. He knew she had been refusing food and medication but also said that she had indicated that she would begin eating and taking her medication again. He could not remember whether he saw the woman’s letter before her death, but he said that if he had, he probably would have thought that she was actually in a positive frame of mind. He knew she was on an ACCT plan and said that he might have telephoned the wing to make sure they were aware of the comment. He said that he was concerned that she might accidentally take her life in a moment of desperation, but that he did not perceive her to be someone who was determined to die.
115. On 30 November, the woman agreed to collect her medication if it could be prescribed for collection once a day. The nurse on duty agreed to discuss this with a doctor. Later that day, a doctor checked the woman’s most recent blood test results and decided that her warfarin dose needed to be increased.
116. The woman began collecting her food as normal on 1 December. On 2 December, an officer talked to the woman who said that she was okay and was eating again.
117. On 3 December, the woman went to the healthcare department to collect her medication. She told a nurse that she had eaten and drunk a very small amount that day. The nurse decided to refer her to the mental health team for review. A nurse from the mental health team recorded that the referral had been received later that day, but that the woman was already being seen by the consultant psychiatrist. The nurse booked her another appointment with the psychiatrist.
118. At 4.00pm on 3 December, a senior officer chaired another ACCT case review, attended by the woman and an officer. The SO recorded that she seemed in much better spirits and said that she was eating biscuits and other food now and then. The SO did not record that the group had discussed any of the issues raised when the ACCT was opened or that the caremap had been reviewed. However, the officers agreed that her risk was now low and

that the observation level could be reduced to one conversation a day and three checks overnight.

119. The officer who was present at the ACCT case review on 3 December said that the woman was adamant that she did not need to be on an ACCT plan, and that it was interfering with her use of the gym. (Prisoners on ACCT plans are not always able to use the gym in the evenings because staffing levels are sometimes insufficient to monitor them properly.) The officer said that they discussed healthy eating and exercise again because she seemed set on eating less and exercising more to lose weight.
120. The officer said that the woman often talked to officers about issues with her post and so she could not remember whether the matter had been discussed in the ACCT review.
121. On 6 December, a senior officer held another ACCT case review and recorded that an officer was also present. At interview, the officer said that she was not present at the review. The woman attended. The SO judged the woman's risk as low and wrote that most of her issues had been related to her medication, and were now resolved. She told the SO that she had no thoughts of self-harm or suicide and the SO closed the ACCT. The officer said that she found out the ACCT had been closed only when the woman told her so.
122. The senior officer told the police that the officer was also present at the review meeting on 6 December. However, when interviewed by the Ombudsman's investigator, he said that the officer was not present at the review, and he had mistakenly recorded that she was. In fact, the review took place with just him and the woman present. The SO's actions were subject to an investigation by the police and are now being investigated by the Prison Service.
123. The SO told the investigator that, before chairing the review, he discussed the woman with this particular officer and F wing officers. However, he said that the decision to close the ACCT was his, because she was collecting food and taking her medication. He thought her interactions with officers were positive and regular and she seemed in good spirits. He said that she was keen to use the gym more often and was in the process of arranging an inter-prison telephone call to speak to her grown-up child. He thought that these were positive indications that she was making plans for the future. He said that he could not recall discussing her issues with access to her post or her relationship with her offender supervisor, although this had been raised as an issue in the earlier case review. As he considered that both of the entries on the caremap had been resolved, he was content to close the ACCT plan.
124. The woman spoke to her partner almost every day and sometimes several times a day. On 6 December, they spoke and she told him that the ACCT plan had been closed. She said that she was worried he would leave her and that, since meeting him, she had never felt so happy.
125. On 8 December, the woman spoke to her sister and said that she was feeling better than she had been over the previous few weeks. She said that she had tried to hang herself a few weeks earlier and her sister encouraged her not to think that way. She said that her relationship with her partner was okay but

that sometimes she could not cope with the problems they had. The next day, she spoke to her partner, and still appeared to be anxious about the state of the relationship. It also seems that she was concerned about her physical health and talked of an upcoming hospital appointment (there are no details of such an appointment in her medical record). At the end of their final call, at about 10.40am on 9 December, she said that she would not do “anything stupid”.

126. Over a weekend in December, the woman took part in wing based activities including karaoke and she helped to decorate the wing Christmas tree. A fellow prisoner who had the room next to the woman, said that she seemed like her normal, bubbly self and did not seem down but she thought it was strange that she gave away to another prisoner some Christmas cards. (In the Ombudsman’s experience, it is not unusual for prisoners who are planning suicide to give away items in the days leading to their death.) However, her neighbour on the wing and also a friend of the woman said she often gave things to other prisoners, so they did not think too much of it. On 8 December, her personal officer made an entry on P-Nomis, noting that her mood seemed to have dipped in recent weeks and that she had said she was missing her partner and struggling. However, the officer wrote that, in the past week, her mood had improved and she had been talkative, sociable and helpful – her “normal self”. The officer recorded that she had no major concerns about her.
127. A fellow prisoner and friend said that she visited the woman in her cell at about 5.00pm on an evening in December to say goodnight. She said that the she was lying on her bed and waved and said goodnight. She said that her friend seemed okay. About 15 minutes later, her next door neighbour on the wing spoke to the woman. She told the police that she asked the woman to wake her at 7.15am the following day, which she agreed to do. Her neighbour had no concerns about her.
128. An operational support grade (OSG) was on duty on F wing that night. He completed a roll check at 9.00pm, during which he checked the occupant of each cell on F wing by looking through the observation panel in the cell door. When he checked the woman, he said she was sitting up in bed and waved and smiled at him. He asked if she was okay and she replied that she was. The OSG continued the roll check but remembered that the woman was due to work in the kitchen the following morning so he returned to her cell to remind her. She told him that she knew and he described her as in good spirits.
129. At about 10.15pm, the woman’s next door neighbour on the wing said that she heard a noise coming either from the cell above hers or from the woman’s room. She thought it sounded like someone or something falling, and considered using her cell bell to call for staff. However, she said that prisoners are punished for misusing the cell bell (which is intended for emergency use only) and so she decided against it. She did not hear anything further from the woman’s room that night. The OSG told the investigator that the woman did not press her cell bell during the night.
130. The OSG carried out another roll check at 3.00am. He said that night staff are expected to check the prisoners once at some point between midnight

and 3.00am. He explained that staff can carry out the check whenever they want between these times and that prisoners do not know exactly when they will be checked.

131. When the OSG reached the woman's cell, at about 3.02am, he looked through the observation panel but it was obscured by the open bathroom door. (On F wing at Foston Hall, prisoners have an en suite bathroom in their cells. When the bathroom door is fully open it blocks the view into the cell.) The OSG knocked on the woman's door and called her name, but got no response. He then radioed for available staff on duty to attend. He confirmed that according to prison policy, if life is at risk, he can go into the cell. (At night, staff carry a cell key in a sealed pouch for use in an emergency.) Because he could not see into the cell, he decided to ask additional staff to attend.
132. A senior officer was the orderly officer in charge of the prison that night. She heard the OSG's radio call and went to F wing with three officers. They arrived at the woman's cell within minutes and one of the officers unlocked the woman's cell using the cell key from her sealed pouch. The officer and the night orderly officer went into the cell and found the woman on the cell floor with the belt of her dressing gown loosely tied around her neck. It seems that she had tied one end of the belt to the window latch and was sitting on a chair placed just under the window. As she fell forwards, it appears the belt came untied from the latch. The officer used her anti-ligature knife to cut the belt and the night orderly officer checked for signs of life. In her incident statement, she wrote that the woman was very cold to the touch and that her body was stiff (this indicates that rigor mortis, the natural stiffening of the body some hours after death, was present). Her skin was blue in colour and there were no signs of life. She had a small injury to the bridge of her nose, which the police told the investigator, may have been caused by her glasses as she fell forwards. The officer radioed for the nurse on duty to attend and the night orderly officer contacted the control room to request an ambulance. A nurse and a healthcare assistant (HCA) arrived at the cell within two minutes and began cardiopulmonary resuscitation (CPR, the delivery of rescue breaths and chest compressions to try to restart the heart and maintain oxygen flow around the body).
133. The nurse said that on their arrival, she and the HCA checked for signs of life and found none. They also attached an automated external defibrillator (AED, a machine which can deliver electric shocks to restart the heart in some circumstances). The AED instructed staff to continue CPR as there was no shockable rhythm. She said that she and the HCA continued CPR until the paramedics arrived.
134. According to the control room log, the emergency ambulance was requested at 3.08am. However, the OSG told the police that, once the other officers had arrived, he continued the roll check and then returned to the wing office. While there, he spoke to a paramedic by telephone seeking an update on her condition. He said that he thought he told the paramedic that she had died. It seems that this information led to some confusion and that the original ambulance request was cancelled. At interview, the OSG could not recall who he had spoken to or what he had said. On learning that the paramedics thought they were not required, the night orderly officer reiterated that the

ambulance was required and the control room made a second call at 3.43am. Two ambulances arrived at Foston Hall at 3.58am, with the paramedics reaching the woman at 4.05am. At 4.10am, after carrying out their own checks, the paramedics pronounced that the woman had died.

135. After the woman's death, her room was searched and what appears to be a suicide note was found. In the note, she thanked wing staff for all they had done for her and wrote about how much she had loved working in the kitchen. She wrote about her relationship with her partner and that despite their problems, she loved him.

### **Contact with the woman's family**

136. The woman's listed next of kin was her partner, who lived in Huddersfield. The prison family liaison officer reached his home at about 9.00am that morning, but he was not there. She telephoned him and they arranged to meet at a different address, where the family liaison officer told him of his partner's death.
137. The family liaison officer telephoned the woman's sister and eldest son on 12 December. The woman's sister arranged the funeral and the prison offered help with the cost, in line with national policy. The FLO liaised with the prisons holding other members of the woman's family to ensure that they were informed of her death.
138. Several members of the woman's family visited Foston Hall in December to see her cell and meet staff and prisoners.

### **Support for prisoners and staff**

139. Prisoners interviewed as part of the investigation said that, generally, they had been well supported by staff after the woman's death. However, prisoners on some wings had not been informed of her death promptly and had not learnt the news until they reached their work placements. A memorial service, attended by many of her friends, was held at Foston Hall.
140. Most staff also said that they had been well supported. A hot debrief for staff who had responded to the emergency was held on the morning of the woman's death. The violence reduction coordinator said that she was not told of her death when she first arrived at work that morning and so did not break the news to prisoners on her wing. She thought that all senior officers should have been told as a priority so that they could offer support to prisoners.

### **Post-mortem report**

141. The post-mortem report concluded that the woman died as a result of hanging.

## ISSUES

### Assessing and responding to the woman's risk of suicide

142. Prison Service Order 4800: Women Prisoners, details some of the specific issues facing many women in prison. It highlights that one in ten women prisoners will have attempted suicide, and half of all self-harm incidents in prison are committed by women, although they make up less than ten per cent of the total prison population. Many women entering prison are already struggling to cope with a range of issues, such as domestic violence and abuse, mental health problems and family issues. These are all significant risk factors for self-harm and suicide.
143. By December 2012, the woman had served nine of the 20 years of her life sentence. However, she had entered custody with a number of the risk factors detailed above. She said she had suffered domestic violence and abuse, she had a history of mental health problems and had family issues, including separation from her 12 children and only limited contact with a few family members. Her relationship with her partner was very important to her, but it was a complicated relationship. When it was going well, it acted as a strong protective factor. However, when there were problems, she was badly affected and spoke about not being able to continue without him.
144. Most interviewees said that although the woman talked about feeling low, and having thoughts of self-harm and suicide, they did not consider her to be at high risk of suicide. When she talked about her past attempts at suicide, she described them as impulsive, but said that she had wanted to die. Her offender supervisor was the only interviewee who said he was concerned that she might accidentally kill herself.
145. The woman was monitored on ACCT procedures numerous times during her sentence, and this continued at Foston Hall. She often told staff that she thought about suicide and that she had attempted to harm herself by various methods. The latest ACCT plan was closed on 6 December, a few days before she was found in her cell with a ligature around her neck.

#### *The ACCT process*

146. As part of the investigation, we have reviewed the various ACCT plans and have some concerns about how ACCT processes are managed at Foston Hall. Some of our concerns are similar to those already raised by HMIP in their last two inspections.
147. One of our primary concerns is the extent to which ACCT case managers and staff involved in ACCT reviews properly engaged with and addressed the woman's identified issues. On more than one occasion, an issue was identified when the ACCT was opened, during the assessment process or at an early case review but was not returned to or discussed at later reviews. For example, an ACCT was opened on 24 September when she said that she would not be able to cope if anything happened to her partner during a serious operation due to take place on 1 October, but the ACCT plan was closed on 25 September. There was little evidence that serious consideration had been given to her anxiety about her partner's operation. The reason for

opening the ACCT had not been resolved and it should not have been closed. Similarly, when the last ACCT was opened on 24 November, the issues centred on her belief that her post was being withheld from her, and as a result, her deteriorating relationship with her offender supervisor. The ACCT plan contains little evidence that these issues were discussed in any detail at subsequent reviews or that they were resolved by 6 December when the ACCT was closed.

148. The caremap for the final ACCT opened bore little relation to the woman's issues. One of the entries focused on encouraging her to interact with staff. By all accounts, this was something she did frequently and readily and was not a problem that needed to be addressed.
149. The woman's ACCT plans identified a range of issues, including her physical health, her attitudes to food and exercise and problems with the offender management unit. However, not a single case review was multidisciplinary. The nurse who opened two of the woman's ACCT plans and her offender supervisor said that there was good communication across departments. They said that they were usually informed of any relevant issues arising from the ACCT process but neither could recall having been invited to a case review for her, or being asked to contribute to the process in any way. PSI 64/2011 makes clear that ACCT reviews should be a multidisciplinary process and HMIP raised this issue in both the 2009 and 2012 inspections. It is disappointing that, at least in this woman's case, the prison had not made any progress towards addressing this.
150. While the woman was often monitored on an ACCT, the case management of the ACCT plans changed from review to review. In one ACCT, three officers acted as case manager within the space of a couple of weeks. Consistent case management can help the prisoner to share their thoughts and feelings more readily, which in turn allows for the officer to better understand the prisoner's triggers and risks. We make the following recommendation:

**The Governor should ensure that ACCT processes at Foston Hall are delivered effectively and in line with PSI 64/2011.**

151. Around 27 November, while still being monitored under ACCT procedures, the woman wrote a letter to a senior officer and her offender supervisor in which she said that she sometimes just wanted to die. In a confidential access complaint submitted to the Governor at about the same time, she wrote about her intention to refuse fluids and suggested that the prison would soon be dealing with the aftermath of her death in custody. Neither the Governor nor the senior officer were concerned by what she wrote or thought that it suggested she was seriously considering suicide. The senior officer knew the woman was on an ACCT plan, and said that she spoke to F wing staff after the meeting. However, she did not refer the letter's contents to wing staff or the safer custody team, or make an entry in the ACCT plan. The Governor did not discuss the contents of the complaint with either F wing staff or the safer custody team and the ACCT was not updated. While they might not have interpreted the woman's words as indicating any increase in her risk, all information relating to risk of suicide should be recorded in the ACCT and passed to relevant wing staff and, if necessary, the safer custody team.

152. We have also identified two occasions when an ACCT should have been opened and was not. On 26 July, the woman told a nurse from the mental health team she often had suicidal thoughts, and on 22 October, she told a further nurse that she had stopped taking her medication, was not eating properly and did not care about the consequences. We make the following recommendation:

**The Governor should ensure that an ACCT is opened whenever there is any information which suggests a prisoner is contemplating suicide or self-harm and that an entry is made in the ongoing record when a prisoner is being monitored under an ACCT plan.**

153. The Governor and some other interviewees, including healthcare staff, were unaware of the database, accessible to all staff, which lists the prisoners currently on ACCT plans. It is important that all staff, across all disciplines, know how and are aware of when to check whether a prisoner is on an open ACCT plan:

**The Governor should ensure that all staff know how to access the database detailing all prisoners on open ACCT plans.**

*The decision to close the ACCT on 6 December*

154. The senior officer's decision to close the ACCT on 6 December, days before the woman died, has also been considered by this investigation. He said that he took into account the views of wing staff who, he said, reported that she was eating again, taking her medication and interacting well with them. He felt that she was making plans for the future and seemed in good spirits. This view is supported by the interviews with other staff and the woman's friends. However, as we have already discussed, there is no evidence that the issues which had led to the ACCT being opened had been fully resolved and, on that basis, it should not have been closed.
155. We accept that, had the ACCT remained open, it is very unlikely that the level of observations would have been raised from one conversation a day and three observations during the night. ACCT observations do not, in themselves, keep someone alive and we cannot say that the outcome would have been any different had the ACCT monitoring continued. We have not seen any evidence to suggest that, in the days leading to her death, the woman's risk should have been perceived to be so high that she needed to be constantly monitored.
156. The woman's family asked why items she could use to harm herself had not been removed from her room. Removing items from a vulnerable person's cell can increase stress levels and, therefore, the risk. For that reason, items are generally only removed when there is strong evidence that the prisoner may use them to self-harm. We do not think that there was sufficient evidence to believe that items needed to be removed from her cell and consider that to have done so would have been disproportionate to the risk. (Although this should have been discussed at ACCT reviews.)
157. We are concerned that no other staff were present at the ACCT review on 6 December when the senior officer decided to close the ACCT. This is not

acceptable and we are surprised that the safer custody manager, who ought to be modelling best practice to other officers, held the case review alone. As the matter is being investigated we make no recommendation about the apparent incorrect record that another officer was present.

### **Addressing the woman's mental and physical health needs**

158. A doctor appointed by Derbyshire County Primary Care Trust conducted a review of the clinical care the woman received at Foston Hall. He concludes that, overall, the care she received was of the same standard as what she would have received in the community.
159. The woman had some potentially quite serious physical health problems, including a risk of blood clots for which she was prescribed warfarin. Patients on warfarin require regular blood tests to ensure the correct dose is given. The clinical reviewer finds that Foston Hall carried out regular and appropriate checks. When she stopped taking her medication, including warfarin, the risks were clearly explained to her. He notes that the management of the woman's high blood pressure was also appropriate. He writes that other medical problems which were diagnosed while she was at Foston Hall were managed effectively and promptly, including appropriate referrals for hospital care.
160. At certain points, the woman told staff that she was not eating properly and appeared to lose weight as a result. However, her weight remained above the ideal weight for her height. The clinical reviewer notes that healthcare staff made several attempts to identify the causes of her food refusal, which were apparently complex, but she was reluctant to discuss her reasons. The clinical reviewer concludes that, in his view, there is insufficient evidence to suggest that her food refusal was part of an organised plan to end her life.
161. In December 2011, the woman was prescribed anti-depressant medication again and in August 2012, the dose was raised. The clinical reviewer notes that, in general practice, the assessment of depression includes the use of standardised tools to aid diagnosis, such as the PHQ9 questionnaire. The assessments also cover whether the patient felt like life was worth living and the risk of self-harm. There is no evidence that any such assessments were used at Foston Hall or that there was any formal assessment before anti-depressants were re-prescribed. He also writes that it is normal practice to review a patient within four weeks of prescription of anti-depressant medication. If there were any concerns about the risk of self-harm, review might take place sooner. In this woman's case, there was apparently no formal review of her mood by the primary care team once she was prescribed mirtazapine. The clinical reviewer makes the following recommendation, which we endorse:

**The Head of Healthcare should introduce a documented assessment of risk of self-harm for patients presenting with depressive symptoms and clear, documented and agreed plans to monitor the effectiveness of any subsequent treatment.**

162. While at Foston Hall, the woman was referred to the mental health team and had two appointments with a consultant psychiatrist. The consultant

psychiatrist did not think that she had a serious mental illness and thought it unlikely that she would have been seen by a psychiatrist in the community. However, he said that because the psychiatric input at Foston Hall was insufficient to meet demand, he was only able to offer 20 minute appointments. He said that in the community, he allocated one hour to each patient and had half an hour to write up his notes. This meant that his assessments of prisoners (including this woman) and subsequent entries in their medical records were much less detailed than in the community.

163. The clinical reviewer concludes that the provision of mental health services at Foston Hall may be inadequate for the need. Moreover, provision may not be used to best effect as general nurses at Foston Hall are able to make direct referrals to the mental health team, without input by the prison doctors. This results in high levels of referrals both to the mental health team and to the psychiatrists, some of which would not receive psychiatric input in the community, putting greater pressure on the service. We therefore make the following recommendation:

**The commissioners of the mental health service at Foston Hall should undertake a needs assessment to identify the appropriate level of provision. They should also ensure that referral routes to the mental health team are appropriate and make best use of the resource.**

### **Responding to the woman's allegations of bullying**

164. While at Foston Hall, the woman reported being bullied on several different occasions, by different prisoners. She moved from B wing to F wing because she said she was being bullied.
165. Once on F wing, the woman began to complain that a particular prisoner, Ms A, was bullying her. Several SIRs were submitted by staff with further information about the nature of her concerns. Officers interviewed said that Ms A was known to be both the perpetrator and victim of bullying. Two violence reduction representatives said that they had spoken to staff about the woman's allegations. Despite the accumulating evidence, none of her claims resulted in a detailed anti-social behaviour investigation.
166. The woman was named in one investigation, which was primarily investigating whether Ms A was bullying another prisoner. As part of that investigation, she submitted a statement in which she said that she spent evenings in her cell with the door closed and the lights off, so that other prisoners thought she was not there. The safer custody officer, who carried out the investigation, concluded that there was no evidence of Ms A bullying other prisoners. It seems that the woman was not questioned in any depth about the contents of her statement or that it was taken into account.
167. We conclude that the response to the woman's concerns about bullying was not sufficiently rigorous and was not in line with the prison's local violence reduction policy nor Prison Service Instruction (PSI) 64/2011, the national policy for dealing with violence and anti-social behaviour. We make the following recommendation:

**The Governor should ensure that all allegations of bullying or violence are given proper consideration, and dealt with in line with local and national policies.**

168. The woman's family said that she complained of being bullied by staff at Foston Hall. The investigator listened to a number of telephone calls between the woman and her partner and other friends and family in the weeks leading to her death. She did not mention any problems with staff in those conversations. Officers said that she often sent them cards thanking them for their support. She was apparently happy to talk to officers and most of those interviewed had a good knowledge of her problems and concerns. The note found in her cell after her death thanked wing staff for their support. We have found no evidence to suggest that she had raised any concerns about bullying or victimisation by staff.
169. We have found no evidence to suggest that the woman was the victim of a physical assault in the days leading to her death. Nor is there any evidence to suggest that any single significant event took place shortly before her death which might have led her to take her life.

**The emergency response**

170. The OSG carried out a routine check of all F wing prisoners at about 3.00am on the morning of the woman's death. When he reached the woman's cell, her bathroom door was open and obscured his view into the cell. She did not respond when he called her and so he requested additional staff so that the cell could be opened. The OSG said that he would have unlocked the cell himself had he been able to see what had happened. As he had no idea why she was not responding and was unable to see into the cell, we do not criticise his decision to wait for additional staff but are surprised that he felt the need. The orderly officer and other staff arrived quickly and there was no further delay in entering the woman's cell. Healthcare staff were also very quick to respond and begin CPR immediately.
171. At interview, the emergency response nurse said that she thought rigor mortis was present. However, because she was not qualified to pronounce death, she and her healthcare assistant colleague attempted CPR. They continued CPR until the paramedics arrived approximately 50 minutes later. The European Resuscitation Council Guidelines for Resuscitation 2010 (Section 10) states that "Resuscitation is inappropriate and should not be provided when there is clear evidence that it will be futile". Delivering CPR in such circumstances is distressing for staff and it should not be necessary for staff to be qualified to certify death to decide it is not appropriate to attempt CPR. We make the following recommendation:

**The Governor and Head of Healthcare should ensure that staff are given guidance about the circumstances in which resuscitation is not appropriate.**

172. The night orderly officer requested an ambulance straightaway, but as noted, it did not arrive for about 50 minutes. In his statement to the police, the OSG said that he spoke to paramedics who telephoned the wing office for an update and told them that the woman had died. He thought that, on the basis

of this information, they might have mistakenly believed they were no longer required. The ambulance service was not able to confirm why the original ambulance request was cancelled, its records simply showed that it was no longer required. When the night orderly officer realised the error, she repeated the request and two ambulances arrived shortly after. The clinical reviewer concludes that, as rigor mortis was present and when the woman was found she had clearly been dead for some time, the delay in paramedics arriving made no difference to the outcome. However, such a delay could have a serious impact in another situation. As it was an internal error that led to the first ambulance being cancelled, we make the following recommendation:

**The Governor should ensure that staff understand when an ambulance should be called and in what circumstances it should be cancelled.**

## RECOMMENDATIONS

The NOMS response is given in italics below each recommendation.

1. The Governor should ensure that ACCT processes at Foston Hall are delivered effectively and in line with PSI 64/2011.

*NOMS accepted this recommendation: "All documentation is now delivered in line with PSI 64/2011. There has been local focus on the improvement of ACCT process and assurances of national requirements. The recent safer custody audit did not highlight any concerns regarding the management of ACCTs. Daily and weekly management checks of all open ACCT documents are carried out. In addition to this, when an ACCT document is completed it is then audited by the Safer Custody Team to identify any areas of concern."*

2. The Governor should ensure that an ACCT is opened whenever there is any information which suggests a prisoner is contemplating suicide or self-harm and that an entry is made in the ongoing record when a prisoner is being monitored under an ACCT plan.

*NOMS accepted this recommendation: "National training in ACCT foundation V5 has been identified for staff to complete. Working in partnership with HMP Sudbury will improve that ability to do this. Work in this area is on going throughout the year. Key staff groups are being prioritised such as reception and Healthcare, and this is a rolling programme."*

3. The Governor should ensure that all staff know how to access the database detailing all prisoners on open ACCT plans.

*NOMS accepted this recommendation: "The Governor has issued information regarding this in staff information notices and ACCT awareness sessions which are regularly held by the Safer Custody Team. Open ACCTs are discussed daily in the morning meeting. All staff has access to the data base, this is being ensured through Annual Staff Reports and regular bi-lateral meetings."*

4. The Head of Healthcare should introduce a documented assessment of risk of self-harm for patients presenting with depressive symptoms and clear, documented and agreed plans to monitor the effectiveness of any subsequent treatment.

*NOMS accepted this recommendation: "This is being explored with the Health Commissioners to agree the best way forward to complete the recommendation. The mental health in-reach provision is not delivered by the same providers for primary health. This work will need joint working across different health providers. A local working group will be developed to take this work forward."*

5. The commissioners of the mental health service at Foston Hall should undertake a needs assessment to identify the appropriate level of provision. They should also ensure that referral routes to the mental health team are appropriate and make best use of the resource.

*NOMS accepted this recommendation: "A full health needs analysis has been requested and the commissioners have agreed to progress this."*

6. The Governor should ensure that all allegations of bullying or violence are given proper consideration, and dealt with in line with local and national policies.

*NOMS accepted this recommendation: "A review of VAS (violent anti-social behaviour) policy has been carried out in February. A new format has been rolled out and is now in place, which is monitored weekly with additional regular policy review. Prisoners who are being managed under the VAS policy are discussed at the weekly complex needs meeting. This process will be continually reviewed."*

7. The Governor and Head of Healthcare should ensure that staff are given guidance about the circumstances in which resuscitation is not appropriate.

*NOMS accepted this recommendation: "The Governor and Healthcare Manager are working together to ensure that guidance is given to all staff. The staff induction process will be used to ensure all new staff are aware of expectations also".*

8. The Governor should ensure that staff understand when an ambulance should be called and in what circumstances it should be cancelled.

*NOMS accepted this recommendation: "A national staff information notice has been published in 2012, which Foston Hall are compliant with, this has been reinforced by staff notices and information bulletins."*