

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of a prisoner at HMP Foston Hall on 10 January 2015

**A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE**

Our Vision

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

Our Values

We are:

Impartial: *we do not take sides*

Respectful: *we are considerate and courteous*

Inclusive: *we value diversity*

Dedicated: *we are determined and focused*

Fair: *we are honest and act with integrity*



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

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

The woman died of an overdose of tramadol poisoning on 10 January 2015, while a prisoner at HMP Foston Hall. She was 33 years old. I offer my condolences to the woman's family and friends.

On the morning of 10 January, the woman collapsed and was taken to hospital where she died later that morning. Tests showed that she had taken a lethal dose of tramadol painkillers. The woman had frequently harmed herself by cutting and had been managed under suicide and self-harm prevention procedures. Monitoring had ended shortly before her death, and the investigation identified some areas for improvement in monitoring procedures.

While there is no evidence that the woman intended to kill herself, I am still very concerned that she was able either to store up her own prescribed medication or to obtain tramadol prescribed to other prisoners. There is a need for the prison to ensure that there are effective arrangements for the safe administration of such potentially dangerous medication. The investigation also identified a need for more sensitive and effective family liaison.

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

September 2015

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Summary

Events

1. The woman was serving a life sentence for murder and had been at HMP Foston Hall since October 2014. The woman had a long history of mental health problems and had gone to Foston Hall to take part in a multi-agency personality disorder treatment programme. When she arrived, a nurse referred her for a mental health assessment, but it was over a month before she was seen.
2. The woman suffered chronic back pain for which she had been prescribed tramadol for some years and received a daily dose of 300mg under supervision in the prison's healthcare centre. She also took a number of other prescribed medications, including antidepressants.
3. The woman frequently self-harmed by cutting and prison staff used Prison Service suicide and self-harm prevention procedures, known as ACCT, a number of times to monitor and support her. ACCT procedures ended four days before the woman died.
4. Shortly after 9.00am on 10 January 2015, the woman collapsed but came round quickly. An officer radioed for medical help and a nurse arrived very quickly. The woman appeared pale and clammy and told the nurse that she could not hear properly and could not feel her lower limbs. She said she had not taken any drugs. The nurse asked for an emergency ambulance as she believed that the woman might have had a stroke. Shortly afterwards she lost consciousness. Other nurses attended and gave her oxygen and began chest compressions.
5. Paramedics arrived and took over emergency treatment. The woman regained consciousness and, with help, was able to stand and get onto the ambulance trolley and was taken to hospital. She died in hospital, later that morning. Post-mortem tests indicated that the woman had died from tramadol toxicity.

Findings

6. The clinical reviewer was satisfied that the care the woman received at Foston Hall was equivalent to that she could have expected in the community. He identified some areas of good practice but noted that there had been a delay in an initial mental health assessment. We are concerned that the woman was able to obtain sufficient quantities of tramadol to take a fatal dose. The most likely source was tramadol that she had pretended to take and stored or that she had obtained some from other prisoners who had done the same thing. To help avoid this, we consider there is a need for closer supervision of administration of medication, which is likely to be diverted or misused.
7. The woman was not being monitored under ACCT procedures when she died, but we have some concerns that the procedures were not managed properly. There was initially a delay in informing the woman's family that she had been taken to hospital and the prison needs to make sure that next of kin details are

kept up to date. Arrangements for the woman's mother to attend the prison after her death were not well managed and she was prevented from meeting and thanking the prisoners who had helped her daughter when she collapsed.

Recommendations

- The Governor and Head of Healthcare should ensure that there are effective arrangements for the safe administration of medication with appropriate checks that prisoners have taken their medication under supervision.
- The Governor should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including that:
 - Multidisciplinary case reviews are held with all relevant people involved in a prisoner's care;
 - Considering all known risk factors when determining the level of risk of self-harm;
 - And setting caremap objectives to address the underlying causes of a prisoner's distress
- The Governor should ensure that next of kin records are accurate and up to date, that families are notified as soon as possible when a prisoner becomes seriously ill or dies, and that liaison with bereaved families is managed sensitively to meet their reasonable needs.

The Investigation Process

1. The investigator issued notices to staff and prisoners at HMP Foston Hall informing them of the investigation and inviting anyone with relevant information to contact him. No one responded.
2. NHS England commissioned a clinical reviewer to review the woman's clinical care at the prison.
3. The investigator obtained copies of the woman's prison medical records and relevant extracts from her prison records. The investigator interviewed four prisoners at Foston Hall on 21 January. The investigator and clinical reviewer interviewed two members of staff on 14 May.
4. We informed HM Coroner for Derby and South Derbyshire of the investigation, which was suspended until we received toxicology results and a cause of death. The coroner's office sent the investigator the cause of death and post-mortem report on 21 April 2015, and we resumed the investigation. We have sent the coroner a copy of this investigation report.
5. One of the Ombudsman's family liaison officers spoke to the woman's mother to explain the investigation process. The woman's mother asked the investigation to consider whether the prison should have contacted her sooner, after her daughter had collapsed on 10 January. She also asked him to consider why the need to have identification with her when she visited the prison on 4 February had not been explained and why, during that visit, she was unable to see the prisoners who helped her daughter after she collapsed.
6. The woman's mother received a copy of the draft report. The solicitor representing her wrote to us pointing out a factual inaccuracy and the report has been amended accordingly. They also raised a number of questions that do not impact on the factual accuracy of this report. We have provided clarification by way of separate correspondence to the solicitor.
7. The Prison Service received a copy of the draft report. They submitted an action plan detailing what they have done to address the issues we raised and this is included at the end of the report. They also pointed out a factual inaccuracy, which has been amended, and raised a number of questions that do not impact on the factual accuracy of this report. We have provided clarification by way of separate correspondence.

Background Information

HM Prison Foston Hall

8. HMP Foston Hall is a closed women's prison serving courts in the Midlands. It holds up to 310 prisoners in a wide range of categories, including unconvicted and unsentenced women, short and long term young adult women under 21 and sentenced women, including some serving life sentences.
9. Derbyshire Health United provides primary healthcare services. There are daily GP sessions Monday to Friday, with out of hours provision at other times. Three primary care nurses and a healthcare assistant are on duty during the day reducing to one nurse and a healthcare assistant from 8.00pm to 7.15am. Derbyshire Community Foundation Trust provides mental health provision. The prison runs CAMEO, a specialist intervention for women with complex needs and personality disorders.

HM Inspectorate of Prisons

10. The most recent inspection of HMP Foston Hall was in October 2014. The Inspectorate found that Foston Hall did a reasonable job in managing its population and there was good support for the many women vulnerable to self-harm. Support for women with substance misuse issues was mainly good.
11. Health provision was generally good. There was a high demand for mental health provision and most needs were being met, although primary mental health services needed to improve. Inspectors noted that the ability of officers to supervise the administration of medication was difficult because there were two simultaneous queues at the medicine hatches and the space was crowded and cramped. Inspectors found that security arrangements were proportionate but the positive mandatory drug testing rate was higher than they normally saw and women reported particular issues with the diversion of prescribed medications. Continued vigilance was needed to address these challenges
12. Some good offender behaviour programmes were offered and inspectors found that the CAMEO Unit on A Wing gave women with personality disorders an excellent opportunity to address their risks.

Independent Monitoring Board

13. Each prison in England and Wales has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community, who help ensure that prisoners are treated fairly and decently. In its most recently published report for the year to November 2014, the IMB commented that Foston Hall was a well run prison where staff endeavoured to provide a fair and decent service in a challenging environment.

14. The IMB was concerned about the number of complaints received from prisoners about the quality of healthcare and noted that there were no trained mental healthcare staff to respond to emergencies in the evenings and at weekends. The IMB noted that the latest time for dispensing medication was 5.30pm, which they considered was unsuitable for night medication and caused particularly difficulties for those with mental health problems.

Previous deaths at HMP Foston Hall

15. The woman's death was the first at Foston Hall since December 2012. We have raised the issues of next of kin records and the quality of ACCT procedures during previous investigations.

Assessment, Care in Custody and Teamwork

16. Assessment, Care in Custody and Teamwork (ACCT) is the care planning system the Prison Service uses for supporting and monitoring prisoners assessed as at risk of suicide and self-harm. The purpose of the ACCT process 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 supervision and interactions are set according to the perceived risk of harm. There should be regular multi-disciplinary case reviews involving the prisoner. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Key Events

17. On 20 June 2005, the woman was convicted of murder and sentenced to life imprisonment. She spent time in a number of different prisons between 2005 and 2014. On 9 October 2014, following a diagnosis of emotionally unstable personality disorder, she moved from HMP Send to HMP Foston Hall to take part in CAMEO, a multi-agency personality disorder treatment programme.
18. At her initial healthcare screen at Foston Hall, the woman told a nurse, she suffered from fibromyalgia (widespread pain without underlying physical abnormality) and from mental health problems. She said she had a history of self-harm by cutting herself, including an incident of self-harm two weeks earlier. Because of her recent self-harm, the woman was being managed under Prison Service suicide and self-harm prevention procedures (ACCT) at the time of her transfer. The nurse referred her to the prison GP and for a mental health assessment.
19. Before arriving at Foston Hall, the woman had been prescribed antipsychotic and antidepressant medication and tramadol (an opioid medication used to treat moderate to moderately severe pain). On 10 October, a prison GP prescribed a 300mg, daily dose of modified release tramadol in line with previous prescriptions, as well as her other medication.
20. Because of the dangers of abuse, prisoners are not allowed to keep medication, such as tramadol, in their possession. The woman therefore had to collect her tramadol once a day from the healthcare centre. A pharmacist or a nurse supervise women taking medication and prison officers in the healthcare centre are expected to check inside each woman's mouth in an attempt to ensure they have swallowed the medication.
21. The woman had been using illegal drugs, including cannabis, crack cocaine, heroin and amphetamines since the age of 16. During her time in prison, she completed a number of substance misuse treatment programmes. On 15 October, a substance misuse case worker, assessed the woman, who said that she had completed work for her substance misuse problems and did not have any issues at that time. The substance misuse case worker arranged no further substance misuse interventions but told the woman that she could contact her or the peer mentors on her wing, if she felt she needed support.
22. As part of the assessment period of the CAMEO programme, the woman had to attend weekly individual sessions with a psychologist or nurse, three group sessions and to complete three 'enrichment' sessions each week, with the option of additional sessions. Despite some initial reservations the nurse, her lead clinician, described the woman as punctual, motivated and keen to progress. The nurse said that she saw no evidence that the woman took illegal or prescription drugs, other than those prescribed to her.

23. On 22 October, a manager closed the ACCT that had been opened after the woman had self-harmed at Send. Although the woman's personal officer and the CAMEO lead clinician gave verbal feedback, they were not at the review in person. (On 28 October, a post-closure review identified no further problems.)
24. On 23 October, a prison GP reviewed the woman and noted that she had been prescribed tramadol for back and groin pain for many years. She was not convinced the woman had fibromyalgia and suspected sciatica. The GP continued to prescribe tramadol for pain relief.
25. The GP and the woman discussed weight management and the GP referred the woman to the prison physiotherapist. The woman had been prescribed diazepam at Send (often used to treat anxiety) and the GP said she would ask the mental health team to review whether the woman's continued to need it.
26. On 24 October the woman's personal officer, spoke to a mental health nurse, as she was concerned that the woman was very anxious. The mental health nurse said she could not see the woman as the mental health in-reach team had not received a referral. It is not clear what happened to the referral made in reception but the healthcare manager, arranged a further referral.
27. On 29 October, the GP saw the woman again and continued her prescription of tramadol. She did not prescribe any further diazepam as she wanted to wait until the mental health team assessed the woman.
28. On 4 November, the tenth anniversary of her offence, the woman spoke to a nurse and the personal officer spoke to her later. She said the day brought up a lot of emotions and filled her with guilt and remorse. They spoke of the support available to her and the woman said she wanted to cope with her emotions without resorting to self-harm.
29. On the morning of 5 November, the woman told a custodial manager, and the personal officer that she was doing okay but felt out of sorts. She said that the mental health in-reach team had still not contacted her and the doctor had stopped her diazepam prescription without consulting her. The personal officer established that the GP had decided not to prescribe more diazepam, until the mental health team assessed her.
30. At 12.30pm on 5 November, the woman rang her cell bell and officers found she had cut her upper right arm. A nurse cleaned and dressed the wound and arranged a follow up appointment. The custodial manager opened an ACCT plan and completed the initial assessment. The woman said that she was struggling to deal with her emotions and thoughts, but that she was not thinking of suicide or of harming herself again. The custodial manager noted the

woman's long history of self-harm and that her last such behaviour, when she cut her wrists, was in April. The woman said that she did not tie things around her neck or take drugs as a form of self-harm.

31. The custodial manager, the personal officer and the woman met for the first ACCT case review shortly after. The custodial manager spoke to the ACCT assessor and the CAMEO lead clinician before the review. At the review, the woman said that she had no more thoughts of self-harm and no thoughts of suicide, but said she was having trouble sleeping. The review assessed the woman as at raised risk of suicide and self-harm and instructed staff to have two conversations with her each day and check her four times during the night. The custodial manager made four entries in the ACCT caremap, noting that the woman needed a doctor's appointment to discuss her medication and to be seen by the mental health team. The custodial manager wrote that staff should help motivate the woman to keep her cell and herself clean. She also recorded that staff needed to be mindful that the ten year anniversary of the woman coming into prison was approaching.
32. On 10 November, the mental health nurse saw the woman and recorded that she had still not been placed on the mental health team waiting list. However, because she had self-harmed, and staff were concerned about her, she decided to assess her without waiting for a formal referral. The mental health nurse recorded that the woman had a history of mental health problems and noted that the prison GP had not renewed her diazepam prescription. The mental health nurse referred the woman to the psychiatrist to review her medication.
33. On 11 November, the custodial manager chaired another ACCT case review with a wing officer, the woman and the CAMEO lead clinician. The woman said that she had not harmed herself since the last review and felt more settled on the wing. She had seen someone from the mental health team and was due to see a psychiatrist and an occupational therapist. The panel assessed the woman as at low risk of suicide or self-harm and left the frequency of checks unchanged.
34. On 13 November, the GP reviewed the woman, and the woman asked her why she had stopped her diazepam prescription. The GP explained she had asked the mental health team to review the prescription. She noted that the woman remained on the list for physiotherapy and continued to prescribe tramadol for pain relief.
35. On 19 November, a psychiatrist the mental health in-reach team manager, and a forensic psychiatrist, reviewed the woman and her medication. They diagnosed that she had an emotionally unstable personality disorder and agreed she should continue on her current medication but with the addition of 10mg diazepam as required to manage her mood. The frequency of its use would be monitored. The psychiatrist arranged tests to check her heart, blood, liver function and

thyroid. He agreed to review [the woman] in two months, or sooner if the results of tests indicated this was necessary.

36. On 25 November, the woman had a physiotherapy appointment. She said she had suffered from lower back pain for a number of years which she controlled using tramadol and a TENs machine (a small, battery operated device that can provide pain relief through electrical stimulation of the nerves). The woman said she was very concerned about the possibility of her tramadol being reduced. The psychiatrist advised some specific exercises, increased use of TENs and some pain management education.
37. On 25 November, the custodial manager and the personal officer held another ACCT case review with the woman. A nurse gave verbal input before the review. The staff agreed to close the ACCT as the woman had not harmed herself, and said she had no thoughts of doing so. The woman said that she felt in a rut and missed her friends at Send but was starting to mix with other prisoners.
38. The next day, the woman told the mental health nurse that she believed having diazepam re-prescribed had helped her. She said she did not feel supported at Foston Hall and had considered asking to go back to Send. They discussed the pros and cons of this.
39. On 2 December, the woman told the personal officer she felt alone after several of her friends had moved off the wing. The personal officer reminded her that she had other friends and encouraged her to come out and mix with others during the evening association period. The woman's mood appeared to improve.
40. On 9 December, at her second physiotherapy appointment, the woman told the psychiatrist her back pain had improved with stretching exercises and increased use of TENs. The psychiatrist have the woman introduced a progressive strengthening programme of exercise.
41. At 5.55pm on 13 December, the woman rang her cell bell and told an officer she had cut herself with a razor blade. The officer could see blood on her left upper arm. The nurse attended and dressed the cuts. The woman said she felt down but did not have suicidal thoughts. The nurse recorded that, when she left her, the woman appeared bright. A custodial manager opened an ACCT plan and directed staff to observe her hourly.
42. The next day, the woman told the nurse that she felt low after a recent visit from her mother, as she realised she would not see her again for some time. She questioned the benefit of the CAMEO course. The woman continued to take diazepam, which she had last taken the previous day, but said she still felt the need to self-harm.

43. At 4.00pm, the officer assessed the woman as part of the ACCT process. The woman said that she was fed up with her life, was not enjoying the CAMEO course and had few friends on the wing. The woman told the officer that she felt frustrated and was not sleeping. She said that she still had thoughts of self-harm but was not feeling suicidal.
44. Twenty minutes later, a supervising officer chaired the first ACCT case review with the woman. The officer and an unnamed member of healthcare staff were also present. The supervising officer wrote that the woman was fed up and did not think the CAMEO course was helping. She said that she continued to have thoughts of harming herself but would not act on them. The review assessed the woman as at low risk of suicide or self-harm. The supervising officer noted one issue on the caremap, that the woman was low in mood, with an action to talk to the chaplaincy team on 16 December. The panel instructed staff to record three conversations with the woman each day and check her once an hour when she was locked in her cell and overnight.
45. On 19 December an acting custodial manager, the woman and the personal officer met for a second ACCT review. No member of healthcare staff or staff from the CAMEO programme attended. The woman said that she was frustrated with the CAMEO course and being away from her friends at Send. However, she wanted to continue with the course. The panel assessed her as at low risk of suicide or self-harm and did not adjust the level of observations. They did not make any new entries in the caremap.
46. On 23 December, a nurse recorded that the woman continued to engage well with the CAMEO programme. She had completed the assessment stage and was considered suitable for the next stage, which was due to start in January. She said the woman was punctual and appeared motivated.
47. On 24 December, the psychiatrist reviewed the woman who said that she found the time of year difficult but had made efforts to participate in her therapy and settle on the wing. The woman said she had no thoughts of suicide and self-harm and that she used diazepam appropriately, no more than once a week. They discussed her prescription of risperidone (an antipsychotic drug), and agreed they would try to reduce the dose. The psychiatrist recorded that the current treatment would continue and planned a further review in February 2015.
48. At approximately 6.30pm on 26 December, the woman told the officer that she had cut her right arm several times with a razor blade, in the shower. The nurse dressed the wounds. The woman said that she had been angry and frustrated, as she had gone to the medication hatch to ask for some diazepam but had been refused as her prescription had not been rewritten. The nurse checked with the doctor the next day who re-wrote the prescription.

49. The SO and an officer and the woman met for an ACCT case review shortly after. The woman said that she had cut her arm because she had been frustrated about her medication. The SO wrote that healthcare staff were aware of the woman's concerns and were dealing with it. The panel did not make any new entries in the caremap. They increased the level of ACCT observations to two every hour.
50. On 30 December, the custodial manager, the personal officer and the woman met for another ACCT case review. The custodial manager received verbal briefing from the CAMEO lead clinician, but no member of healthcare staff attended the review. The woman said that she had no thoughts of self-harm or suicide. The woman said that she was finding her one-to-one sessions with the CAMEO clinician helpful and was well supported on the wing. The staff agreed to close the ACCT. On 6 January, The custodial manager held a post-closure review and noted that, while the problems that had led staff to open the ACCT had not been resolved, the woman continued to work with the CAMEO staff.
51. On 31 December, a psychiatrist, prescribed a two-week course of promethazine (an antihistamine with strong sedative and weak antipsychotic effects, often used to treat anxiety). He recommended that mental health in-reach staff should discuss with the psychiatrist if they considered further prescriptions were necessary.
52. On 9 January 2015, a nurse recorded that the woman continued to attend her one-to-one CAMEO sessions and remained motivated and keen to engage. The next phase of the CAMEO programme was due to begin on 12 January.

Events of Saturday 10 January

53. Shortly after 9.00am on Saturday 10 January, the woman and other prisoners were outside the wing office waiting to go to collect their medication, when the woman suddenly fell to the floor. Two prisoners saw her fall. One prisoner said her left leg appeared to give way and she fell backwards.
54. The two prisoners and a third prisoner, went to help the woman and called an officer, who was sitting in the wing office. The woman was initially unresponsive and appeared to be unconscious. The other prisoners put her into the recovery position, and she regained consciousness. She was able to speak but could not remember what had happened.
55. At 9.08am, the officer radioed for medical assistance. He did not use an emergency medical code (which would have alerted the control room to call an ambulance), as he believed that the woman had just tripped or fainted. An officer placed a duvet under the woman's head to make her more comfortable. He asked her if she had any pain and she said that she could not hear properly. The officer said she was disorientated and tried to get up and said she had to go to

work. The officer persuaded her to remain where she was until healthcare staff examined her.

56. The nurse arrived after only a few minutes and the nurse joined him moments later. The woman was still on the floor in the recovery position. They described her as pale and clammy. The nurse believed she may have suffered a 'cardiac event'.
57. The woman's condition improved slightly and the nurses moved her to a nearby sofa. The woman said she thought she had fallen and that she could not hear through her right ear or feel her lower limbs. She told the nurse that she did not have any pains in her head or chest and had not taken any drugs.
58. The woman's condition again began to deteriorate; she fell onto her side and appeared to be having a small fit. At 9.19am, the nurse asked for an ambulance as she suspected the woman might have suffered a stroke. Almost immediately, the woman collapsed and became unresponsive. A nurse asked another nurse to bring oxygen and a defibrillator and radioed for more nurses to attend. The nurse contacted the healthcare unit and two other nurses brought emergency equipment.
59. The nurses laid the woman on the floor. Her blood pressure was within normal range but her heartbeat was abnormally fast at 135 beats per minute. The nurses attached a defibrillator, which advised continued cardio-pulmonary resuscitation.
60. The nurses gave her oxygen and began chest compressions, which continued until paramedics arrived at 9.35am and took over emergency treatment. The woman regained consciousness and spoke to the staff. She could breathe unaided, but they continued to administer oxygen. With some help, she was able to stand and get on the ambulance trolley.
61. In the ambulance, the woman's condition deteriorated and she lost consciousness. The woman did not regain consciousness and, at 11.24am, a doctor at the hospital confirmed that she had died.

Contact with the woman's family.

62. After the woman had collapsed an acting custodial manager, tried to ring the woman's aunt, as her records showed that she was her next of kin. She could get no reply. After a search of the woman's records, the custodial manager found the woman's mother's details and telephoned her at 11.05am to tell her that her daughter had been taken to hospital.

63. The custodial manager went to the hospital and joined the Governor. She arrived shortly before 1.00pm, by which time the woman had died. The custodial manager telephoned the woman's mother to get an expected time of arrival. As she was already travelling, she did not tell her that the woman had died.
64. At 2.45pm, the woman's mother and sister arrived at the hospital. A member of the hospital staff told them that the woman had died. The Governor and custodial manager offered them condolences and support.
65. The custodial manager kept in contact with the woman's family and arranged for her mother to visit the prison on 4 February, to collect some of her daughter's things and to see where she had lived. When she arrived, she was held up at the prison gate as no one had informed her that she needed to bring identification. She asked to see the three prisoners, who had helped the woman when she collapsed but, the Governor consulted the police and would not allow this.
66. The woman's funeral was held on 20 March, and the prison contributed towards the cost in line with national instructions.

Support for prisoners and staff

67. The Governor issued a notice to prisoners and staff informing them of the woman's death and the support available. Staff reviewed women being managed under ACCT suicide and self-harm prevention procedures, in case they had been affected by the woman's death.
68. A senior manager, debriefed prison and healthcare staff involved in the emergency response and offered appropriate support. He debriefed control room staff separately, shortly afterwards. He spoke to the officers who had escorted the woman to hospital, when they got back to the prison.
69. The senior manager personally informed the three prisoners who had been with the woman when she had collapsed and thanked them for their efforts in helping her. He arranged additional staff for the woman's wing and informed the other prisoners on the wing, in small groups later that evening.

Post-mortem report

70. A post-mortem examination concluded that the woman died of tramadol toxicity. A toxicology report noted that tramadol was present in the blood at very high levels, within toxic and lethal ranges. This was not consistent with the woman's prescribed daily dose of 300mg of modified release tramadol, which enters the blood stream gradually. This suggested that the woman had taken a higher dose

of tramadol all at once. The toxic effects of tramadol include reduced consciousness, respiratory depression and seizure.

Findings

Clinical care

71. Overall, the clinical reviewer was satisfied that the woman's care in prison was of a high standard and equivalent to that she could have expected to receive in the community. He did not consider that her death could have been predicted or avoided and highlighted a number of areas of good practice. However, the clinical reviewer was concerned about the initial delay in a mental health assessment and that the woman was apparently able to obtain sufficient quantities of tramadol to be fatal.

Tramadol

72. The woman died from tramadol toxicity. A prison doctor prescribed 300mg of tramadol, to be taken once a day, under supervision. The clinical reviewer was satisfied that this was appropriate.
73. However, post-mortem results indicated a lethal level of tramadol, significantly higher than would be expected from the daily prescribed dose. The clinical reviewer considered an accumulation in the body unlikely as the post-mortem examination found normal liver function and the possibility of an error in the number of tablets taken can be discounted as the woman received only one tablet each day, under supervision. This leaves the possibility of deliberate or accidental overdose. For either of these, the woman would have had to accumulate her medication by concealing it and storing it after she received it or have obtained it from another source in the prison.
74. The woman had a history of self-harm and suffered from mental health problems. She usually cut herself as a means of harming herself. Although her self-harm had been frequent, this was usually a reactive, coping mechanism and there was little to suggest suicidal intent. There is no record that she had taken a deliberate or accidental overdose in recent years.
75. The woman collected her medication from the healthcare unit where a pharmacist or a nurse supervised her taking it. A prison officer is then expected to check inside each woman's mouth before they leave the unit. The pharmacist told the investigator that up to 198 women get their medication this way each day, and there were often 40 or more women queuing at the medication hatch at any one time. She accepted that determined prisoners found ways to conceal it. At the inspection of Foston Hall in October 2014, inspectors noted that officers' supervision was impeded by having to monitor two simultaneous queues and because of the number of women congregating in a small space. Women prisoners in the inspectorate's survey also reported more problems with diverted medication than in other women's local prisons.

76. Medication such as tramadol has a tradable value in prison. Staff should report any prisoner they suspect of concealing or giving their medication to another prisoner, but there were no such reports for the woman. We do not know how the woman obtained enough tramadol to overdose on it, but it is possible that she pretended to take the tablets when she was given them and stored them. It is also feasible that she obtained some from other prisoners. Another prisoner on the woman's wing, told the investigator that the woman frequently 'stored' her medication and took it in one go on a Friday evening to 'give her a buzz'. The prisoner did not report this to prison staff.
77. There is little doubt that the woman took more than her prescribed dose of tramadol and this was lethal. We cannot know for certain whether the overdose was deliberate or accidental. However, it appears possible that the woman hoarded her medication to take at once to obtain a 'high'. We accept that it is a constant challenge in prisons to prevent prisoners diverting their prescribed medication, but the circumstances of the woman's death and the Inspectorate's comments about supervision of medicines queues suggest that greater vigilance in monitoring the issue of controlled medication is needed. We make the following recommendation:

The Governor and Head of Healthcare should ensure that there are effective arrangements for the safe administration of medication with appropriate checks that prisoners have taken their medication under supervision.

Mental Health Assessment

78. On 9 October, at an initial health screen, the nurse referred the woman to the prison mental health in-reach team for assessment. At a follow up reception screen, two days later, the nurse confirmed the need for a mental health assessment. The pharmacist told the investigator that it should take approximately a week for a mental health nurse to see a patient after a routine referral.
79. On 23 October, when the GP examined the woman, the mental health assessment had not been completed. The mental health nurse confirmed that the in-reach team had not received a referral. The pharmacist said she would make another referral. On 5 November, the woman complained that the mental health team had still not contacted her and as a result, the doctor had stopped her diazepam prescription without consulting her.
80. The GP explained to the investigator that the woman had been prescribed diazepam by secondary services at Send. She had taken all the diazepam covered by that prescription and she would not prescribe more until she had an assessment from the mental health in-reach team at Foston Hall. The delay in prescribing diazepam was therefore a direct consequence of the delay in the

mental health assessment. This had caused the woman added anxiety. It was not until 10 November, that the mental health nurse completed a mental health assessment. This was after an incident of self-harm and not as a result of the referral process.

81. It was accepted that this delay should not have happened. As a result of an internal healthcare review, conducted after the woman's death, she had introduced a new process that made better use of the 'task' option on a patient's SystemOne computer medical record, This gives greater responsibility to the person initiating the task to ensure that it has been actioned and should prevent delays like those seen in the case of the woman. The clinical reviewer was satisfied that this was an appropriate solution and we therefore do not make a recommendation.

ACCT Procedures

82. The woman had a long history of self-harm and had attempted suicide before. At the time of her transfer from HMP Send and at other times at Foston Hall, after she had self-harmed, the woman was managed under ACCT procedures. She was not being managed under ACCT procedures at the time she died. (The last ACCT had been closed ten days earlier and she had had a post-closure review four days earlier.) However, we have some concerns about how effectively the ACCT process was managed at Foston Hall, which was not always in line with Prison Service national instructions.
83. On 14 December, staff opened an ACCT when the woman cut her arms. She cut them again on 26 December. Despite these acts of self-harm, her long history of self-harm and previous suicide attempts, and her feelings of frustration and loneliness, staff generally assessed her as at low risk of suicide and self-harm. On the basis of the information staff had about the woman, and on what she said during case reviews, it is difficult to see how she could have been considered at low risk of self-harm.
84. Although a number of the woman's anxieties centred on her participation in the CAMEO course, and later her medication, a member of healthcare staff was present at only one of the ACCT case reviews. The CAMEO lead clinician twice gave verbal briefing before the reviews, but did not attend in person. Prison Service Instruction 64/2011, which covers safer custody, instructs that ACCT reviews must be multidisciplinary where possible. We are particularly concerned that no one from the CAMEO or healthcare teams was present at the review on 30 December, when the ACCT was closed.
85. The woman's last ACCT caremap contained only one entry, made on 14 December, which was that she felt low and had an appointment with a chaplain on 16 December. There were no further caremap actions, although the woman had said she was concerned about the CAMEO course, her medication and her

relative isolation. PSI 64/2011 directs that caremap entries must 'reflect the prisoner's needs, level of risk, and the triggers of their distress. It must aim to address the issues identified in the ACCT assessment interview...Each action on the CAREMAP must be tailored to meet the individual needs of the prisoner and be aimed at reducing the risk to themselves ... ' The woman's caremap did not comply with those instructions. While there is a little to indicate that the woman took a deliberate overdose, it is important that ACCT procedures operate as effectively as possible to ensure that prisoners at risk receive the best possible support to relieve their distress. We make the following recommendation:

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

- **Multidisciplinary case reviews are held with all relevant people involved in a prisoner's care;**
- **Considering all known risk factors when determining the level of risk of suicide or self-harm; and**
- **Setting caremap objectives to address the underlying causes of a prisoner's distress**

Liaison with the woman's family

86. The woman's mother was concerned that she had not been informed that her daughter had been taken to hospital until over an hour after the ambulance had left the prison. While this was not a very significant delay, the prison would have been able to contact her earlier if their records had been up to date.
87. When the woman transferred to Foston Hall, she had completed a next of kin form identifying her mother as her nominated next of kin. This information was not transferred to her prison record. Instead the records showed the woman's aunt as her next of kin. When she was unable to contact her aunt, the custodial manager, the family liaison officer, found the woman's mother's details from her phone records. Sadly, even if the records had been up to date and the prison had been able to inform her immediately, this would not have allowed her mother sufficient time to see the woman before she died. However, prisons have a responsibility to ensure that next of kin details are accurate and up to date. Prison Rule 22 requires prisons to inform the next of kin immediately if a prisoner dies or is seriously ill.
88. The woman's mother was also unhappy with the handling of a visit to the prison on 4 February. The custodial manager had invited the woman's mother to visit. Because she had an appointment with the custodial manager, her mother did not appreciate that she would need the identification she would normally bring for a prison visit and this had not been explained to her. She said the officer at the prison gate had been rude to her and denied her access. (She was eventually able to get suitable identification from her car.)

89. The visit of a bereaved parent to a prison after a death is obviously an upsetting time for them and the woman's mother said that the difficulty getting into the prison added to her distress. We consider that gate staff should have been briefed about this sensitive situation and it would have been better if the family liaison officer had been at the gate to meet her when she arrived.
90. During the visit, the woman's mother had expected to be able to speak to and thank the three women prisoners who had been with her daughter and had helped her when she collapsed. However, the Governor decided, on the advice of the prison's police liaison officer, not to allow this, and suggested to the woman's mother that she should send a card.
91. PSI 64/2011 which gives guidance about family liaison after a death in custody does not give specific guidance given about the arrangements for families visiting a prison after a death but says that all families are different and will have different needs. The intention is to be supportive towards families. Ultimately, it is for governors to decide who they allow families to see, but we do not consider that a supervised meeting between the woman's mother and the three prisoners would have adversely affected any police investigation. We make the following recommendation:

The Governor should ensure that next of kin records are accurate and up to date, that the next of kin is notified as soon as possible when a prisoner becomes seriously ill or dies, and that liaison with bereaved families is managed sensitively to meet their reasonable needs.

Action Plan

No	Recommendation	Accepted/ Not Accepted	Response	Target date for completion and function responsible	Progress (To be updated after 6 months)
1	The Governor and Head of Healthcare should ensure that there are effective arrangements for the safe administration of medication with appropriate checks that prisoners have taken their medication under supervision.	Accepted	<p>Arrangements for the administration of medication and checks that prisoners have taken their medication under supervision will be reviewed in October 2015, under New Ways of Working (NWOW). This will include producing role briefs for staff supervising medication as well as clear accountability for which staff are responsible for completing which checks.</p> <p>A protocol will be agreed for actions to be taken when it is identified that a prisoners does not take their medication as required, especially where intelligence suggests prisoners are trying to divert their medication. This will be published and communicated to staff in October 2015.</p> <p>Management checks will ensure compliance with this protocol.</p>	<p>Governor Head of Healthcare Head of Security and Head of Residence & Safety</p> <p>Target date for completion: 31.10.15</p>	
2	<p>The Governor should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including that:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Multidisciplinary case reviews are held with all relevant people involved in a prisoner's care; 	Accepted	<p>In line with PSI 64/2011 Safer Custody, a new local safety strategy will be implemented in September 2015 with specific guidance on the ACCT process, which will ensure that multidisciplinary case reviews are held with all</p>	<p>Governor - Head of Residence & Safety</p> <p>Target date for completion: 30.09.15</p>	

	<p>□ Considering all known risk factors when determining the level of risk of self-harm; And setting care map objectives to address the underlying causes of a prisoner's distress</p>		<p>relevant people involved in a prisoner's care; all known risk factors are considered when determining the level of risk of self-harm of a prisoner and setting care map objectives address the underlying causes of a prisoner's distress.</p> <p>Management checks will be implemented to confirm the above processes are adhered to. All ACCT Case Managers to receive Safer Custody Refresher</p>		
3	<p>The Governor should ensure that next of kin records are accurate and up to date, that families are notified as soon as possible when a prisoner becomes seriously ill or dies, and that liaison with bereaved families is managed sensitively to meet their reasonable needs</p>		<p>All current prisoners have had their next of kin data reviewed and updated. This work will be ongoing.</p> <p>Personal Officers will complete a monthly check of next of kin details for prisoners they are allocated and record this on P-Nomis even if there is no change. Management checks will ensure compliance with this practice.</p> <p>A Notice to staff has been published 30th July 2015 to all staff making them aware of this, that the local safety strategy mandates the actions required to ensure accurate recording of next of kin.</p> <p>The responsibility for contacting the next of kin will remain with the Governor. This is essential in order to ensure that the next of kin is informed face to face, wherever possible.</p> <p>Family Liaison Officers will continue to be</p>	Complete Governor	

			supervised and supported by an Operational Manager to ensure that bereaved families are managed sensitively and reasonable needs are met.		
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**Prisons &
Probation**

Ombudsman
Independent Investigations