

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Ms Caroline Hunt a prisoner at HMP Foston Hall on 29 September 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.

Ms Caroline Hunt was found hanged in her cell at HMP Foston Hall on 26 September 2015 and died in hospital on 29 September. Ms Hunt was 53 years old. I offer my condolences to Ms Hunt's family and friends. The investigation was suspended at the request of Derbyshire police until they completed enquiries. I am sorry for the consequent delay in issuing this report.

This is an extremely sad story. Ms Hunt had no criminal history and had not been in prison before 2015. She was distressed by her situation and felt hopeless about her future. Although she was managed under Prison Service suicide and self-harm monitoring procedures for three short periods at Foston Hall, I am concerned that these procedures were not managed effectively. While I recognise that the judgements required in these procedures are difficult, staff underestimated the extent of Ms Hunt's risk on the evening of 25 September, just after she received a prison sentence. Sadly, this meant that the level of agreed monitoring was insufficient to protect her.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman

September 2016

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Summary

Events

1. On 29 May 2015, Ms Caroline Hunt was remanded to HMP Foston Hall for threatening to kill her daughter during an argument on 27 May. She had never been in prison before. Staff noted she was nervous and quiet.
2. On 15 July, Ms Hunt was granted bail on condition she did not contact her daughter. On 7 September, she received a suspended sentence, with the same condition. That evening, she telephoned her daughter several times and left three voicemails, threatening to kill her.
3. On 9 September, Ms Hunt was remanded to Foston Hall again. She was distressed and anxious and said she planned to kill herself. Staff began suicide and self-harm monitoring procedures, known as ACCT. The next morning, Ms Hunt cut her wrist with a plastic knife and said she wanted to die. Staff checked her three times an hour, which was reduced to once an hour at a case review the next day.
4. On 16 September, Ms Hunt told a nurse that she would be better off dead and had lost everything. She was anxious, tearful and looked unkempt. A standard depression test indicated she was severely depressed. The nurse referred her to the GP and said she would ask officers to review Ms Hunt's risk. There is no evidence of any review or that the nurse alerted officers.
5. The GP prescribed Ms Hunt medication for depression and anxiety and referred her to the mental health team for counselling. The GP said she was reassured that Ms Hunt was being monitored under ACCT procedures. Later that day, two supervising officers reviewed Ms Hunt and ended ACCT monitoring, although not all the actions identified to reduce her risk had been completed.
6. On 19 September, staff began ACCT procedures again when Ms Hunt said she was feeling low and worried about her imminent court appearance. Although the court case was noted as a trigger and significant event in her ACCT record, staff ended ACCT monitoring at a case review the next day.
7. On 25 September, Ms Hunt was sentenced to 17 months in prison. When she got back from court, a nurse began ACCT procedures again, when Ms Hunt said that her life was over and she had nothing to live for. Staff checked her twice an hour.
8. That night, Ms Hunt's cellmate put a note under the cell door asking to be moved, as Ms Hunt was threatening suicide and she was scared. An officer informed the night manager, who told him to continue monitoring Ms Hunt. Ms Hunt got into bed and appeared to put a plastic bag over her head. Her cellmate alerted staff and said that Ms Hunt had written a suicide note. Ms Hunt said she had been using the bag to condition her hair. Staff found a letter to her daughter, in which she said that her life was over. Ms Hunt said she had written it some time before. The staff decided to move Ms Hunt to a cell on her own and increased her observations from two to three times an hour.

9. The next morning, an officer found Ms Hunt hanging from her bathroom door. Staff and paramedics tried to resuscitate her and managed to restart her heart. Ms Hunt was taken to hospital but died on 29 September without regaining consciousness.

Findings

10. The investigation found a number of deficiencies in the ACCT process, which did not operate effectively. Staff ended ACCT monitoring twice, before Ms Hunt's risk had reduced. On the night of 25 September, staff underestimated Ms Hunt's risk of suicide and did not put in place appropriate arrangements to protect her. Ms Hunt had a number of risk factors that indicated she was at high risk of suicide that night but there is no evidence that staff considered whether she should have been constantly supervised. The move to a single cell increased her risk of suicide considerably but observations were raised from only two to three times an hour.
11. We are concerned that Ms Hunt did not have a mental health assessment despite being identified as at risk of suicide and being diagnosed with depression and anxiety. In this respect, we do not consider her standard of healthcare was equivalent to that she could have expected to receive in the community.

Recommendations

- The Governor should ensure that staff manage prisoners at risk of suicide or self-harm in line with national guidelines. In particular:
 - Staff should hold multidisciplinary case reviews attended by all relevant people involved in a prisoner's care. A member of healthcare staff should attend all first case reviews.
 - Case reviews should consider all known risk factors when determining the level of risk of suicide and self-harm, and set levels of observations which reflect the risk.
 - Case managers should set ACCT caremap actions and review progress against caremaps at each review and not close ACCT plans until all caremap actions have been completed.
- The Governor should ensure that staff fully consider all additional information when further reviewing the risk of prisoners already assessed as at risk of suicide or self-harm. Constant supervision should be considered when indicated, in line with guidance in PSI 64/2011 and all options that were considered, but discounted, should be recorded in the ACCT document.
- The Governor and Head of Healthcare should ensure that prisoners identified as at risk of suicide and self-harm are referred urgently for a prompt mental health assessment.

The Investigation Process

12. The investigator issued notices to staff and prisoners at HMP Foston Hall, informing them of the investigation and asking anyone with relevant information to contact her. Two prisoners responded.
13. The investigator visited Foston Hall on 6 October 2015. She obtained copies of relevant extracts from Ms Hunt's prison and medical records.
14. NHS England commissioned a clinical reviewer to review Ms Hunt's clinical care at the prison.
15. The investigator interviewed eleven members of staff and the two prisoners who responded to the notice of investigation at Foston Hall in October and December 2015 and January 2016. The clinical reviewer joined her for three of the interviews.
16. Our investigation was suspended at the request of Derbyshire police while they completed their enquiries. We regret the consequent delay with issuing this report.
17. We informed HM Coroner for Derbyshire of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
18. One of the Ombudsman's family liaison officers contacted Ms Hunt's daughter to explain the investigation and to ask if she had any matters they wanted the investigation to consider. The investigator and family liaison officer met Ms Hunt's daughter and her legal representatives. Ms Hunt's daughter received a copy of the initial report. They pointed out two factual inaccuracies and this report has been amended accordingly. Ms Hunt's daughter also raised a number of questions that do not impact on the factual accuracy of this report and have been addressed through separate correspondence. We have sent Ms Hunt's daughter and her cousin a copy of this report.

Background Information

HMP Foston Hall

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

HM Inspectorate of Prisons

21. The report of the most recent inspection of HMP Foston Hall in June 2016 has yet to be published. In initial feedback, the Inspectorate noted that there had been four recent self-inflicted deaths, with an action plan to implement recommendations. A high proportion of women said that they had emotional or mental health problems, and the Listener scheme needed expanding to reflect this. A high number of women were monitored under ACCT procedures and case managers were caring and supportive. ACCT records had improved but care maps needed more follow up.
22. The involvement of healthcare staff in ACCT reviews was inconsistent. Women with identified mental health needs were well supported.
23. At the previous inspection in October 2014, inspectors found that support for women at risk of suicide or self-harm was generally good but there was little continuity of case managers. Inspectors considered that the lack of a Listener scheme (prisoners trained by Samaritans to support other prisoners in distress) was a significant omission.
24. Inspectors assessed health provision as generally good. They noted that there was a high demand for mental health services and most needs were met, but primary mental health services needed to improve.

Independent Monitoring Board

25. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to November 2015, the IMB reported that the suspension of the Listener scheme for most of the year due to a lack of Listeners had been a very serious loss to safer custody strategy. A part-time scheme had recently been introduced. Safer custody systems had been reviewed in light of the number of deaths at the prison in 2015. As a result, there were new systems for management checks and to improve consistency of case management.

Previous deaths at Foston Hall

26. Ms Hunt's death was the fourth death at Foston Hall in 2015. One prisoner died from as yet un-established causes in January and there were two self-inflicted deaths by hanging in July and August 2015. In the previous investigations we also found some deficiencies in ACCT procedures.

Assessment, Care in Custody and Teamwork

27. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner.
28. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular multi-disciplinary review meetings involving the prisoner. As part of the process, a caremap (plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the caremap have been completed.
29. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Key Events

30. On 29 May 2015, Ms Caroline Hunt was remanded to HMP Foston Hall for threatening to kill her daughter during an argument with her on 27 May. She had never been in prison before or in any trouble with the police.
31. At an initial health assessment, a nurse noted that Ms Hunt was tearful but rational and did not appear to be at risk of suicide or self-harm. Ms Hunt said she had asthma and high blood pressure. The next day, the nurse saw Ms Hunt for a second health assessment and noted she appeared calm. Ms Hunt had no further significant contact with healthcare staff during this period in prison, except for routine blood tests to check her blood pressure medication. An officer, who worked on D Wing where Ms Hunt lived, said Ms Hunt was very nervous and quiet.
32. On 15 July, Ms Hunt was granted bail, with a condition that she did not contact her daughter. On 7 September, she received a nine month prison sentence suspended for two years, with the same condition. That evening, she telephoned her daughter several times and left three voicemails, threatening to kill her.
33. On 9 September, Ms Hunt was remanded to Foston Hall, charged with putting a person in fear of violence by harassment. A court custody officer completed a suicide and self-harm warning form, as Ms Hunt repeatedly said that she did not want to go to prison and wanted to kill herself.
34. At an initial health assessment, a nurse recorded that Ms Hunt was distressed and anxious and said she had made suicide plans. Her forehead and eyes were heavily bruised. Ms Hunt said this has happened when she had fallen over when drunk. As a precaution, the nurse decided Ms Hunt should be monitored for symptoms of alcohol withdrawal, and referred her to the substance misuse service.
35. On the nurse's advice, an officer began ACCT suicide and self-harm prevention procedures and a Supervising Officer (SO) completed an immediate action plan. Staff were required to check Ms Hunt twice an hour. The SO noted that Ms Hunt should not be allowed to keep any medication in her possession. The SO noted that there was no Listener scheme and offered her the use of a portable telephone with direct access to the Samaritans.
36. At 6.30am the next morning, a nurse noted that Ms Hunt had made superficial cuts to her wrist with a plastic knife. Ms Hunt said she wanted to die and that she could not be in prison. At 10.15am, at a second health assessment, a nurse recorded that Ms Hunt was very tearful. She said several times that her life was ruined and that she planned to kill herself. The nurse increased Ms Hunt's observations to three an hour until an ACCT assessor saw her. A supervising officer completed a basic custody screening to determine immediate resettlement needs. When Ms Hunt went back to her wing, she told an officer that she was worried about paying her mortgage and could not serve a nine month sentence.
37. At 8.20pm, a SO assessed Ms Hunt as part of ACCT procedures. Ms Hunt said she felt anxious all the time and was worried she would lose her home if she received a prison sentence. She said she had never self-harmed or attempted

suicide before but would rather be dead now. She was worried that she would be ostracised by people in her local community for having gone to prison. The ACCT record shows that staff continued to check Ms Hunt three times an hour, throughout the night.

38. At 8.20am on 11 September, a SO held Ms Hunt's first ACCT case review. No other member of staff was present, although it is a mandatory requirement of ACCT procedures that a member of healthcare staff and other relevant staff should attend first ACCT case reviews. Ms Hunt said she would not be able to cope if her suspended sentence was activated. The SO added four issues to the caremap (actions needed to reduce risk) - housing, depression, education and her court case. All the actions were for Ms Hunt. Ms Hunt told the SO that she had already asked for a healthcare appointment for depression. The other actions were for her to apply to the relevant department about her housing issues, complete her induction before applying for education and to attend court on 24 September. Despite Ms Hunt's self-harm, the day before, and her other risk factors, the SO assessed that Ms Hunt's risk to herself was low and reduced the number of observations from three to one an hour.
39. On 15 September, a prison chaplain noted in Ms Hunt's ACCT record that she was very upset and worried about her court case.
40. A healthcare assistant spoke to Ms Hunt several times when she was monitoring her for alcohol withdrawal or changing the dressing on the cuts to her wrist. She said Ms Hunt was very anxious, nervous and agitated, and cried very easily. She said Ms Hunt liked to talk to her and it seemed to cheer her up a little.
41. On 16 September, a nurse examined Ms Hunt after she had asked to see a nurse about pain in her arms and shoulders. The nurse recorded in her medical record that Ms Hunt was anxious and tearful and looked unkempt. Ms Hunt said she would be better off dead, as she had lost everything and would never get it back. Ms Hunt scored 21 on a standard depression test questionnaire (PHQ 9), which indicated she had severe depression. She referred Ms Hunt to see a GP and noted that she would ask officers to review Ms Hunt. It does not appear that the nurse had access to the ACCT record. Other than the fact that Ms Hunt had a healthcare appointment that morning, there is no detail of their conversation in the ACCT record. (We have not been able to interview the nurse as she was an agency nurse and the prison has been unable to contact her.)
42. That afternoon, a prison GP saw Ms Hunt, following the nurse's referral. The GP said Ms Hunt was very anxious about her court case on 24 September and told her that she woke in the night from panic attacks and felt suicidal. Ms Hunt said she had no clear plans about how to kill herself but felt her life was ruined. The GP prescribed citalopram (an antidepressant) and referred Ms Hunt to the mental health team for counselling.
43. The GP told us that she had been very concerned about Ms Hunt's presentation on 16 September. She said she appeared down and anxious and reported thinking about suicide. She said she was reassured that Ms Hunt was being managed under ACCT procedures and had been referred to the mental health team. She did not make an entry in the ACCT record. Entries from wing staff for

the corresponding time indicate that the ACCT record was not taken to the healthcare centre with Ms Hunt, as it should have been.

44. At 5.20pm, two SOs held an ACCT case review. One SO recorded that Ms Hunt was very positive and had made progress with all of her issues. She had seen the GP that day, who had prescribed antidepressants and had made an application for advice about her housing issues. She felt more positive about her court case and said she would apply for a job if she returned to prison. The SO said Ms Hunt looked much better than at her previous review and said she did not feel suicidal. The SO marked all four actions on the caremap as completed and closed the ACCT.
45. Ms Hunt moved to T Wing on 17 September. T Wing is a standard residential wing but does not take prisoners who are being monitored under ACCT procedures, as the cells are not regarded as suitable. On 18 September, Ms Hunt's cellmate told a member of staff that Ms Hunt was feeling down and an officer spoke to her about this. Ms Hunt told the officer that she was upset about being back in prison but had started taking antidepressants and was trying to "get herself together". She said she thought Ms Hunt was just down that day and did not consider she needed to start ACCT monitoring again. She said Ms Hunt was exactly the same as she remembered her from her remand period earlier in the year.
46. On 19 September, Ms Hunt reportedly told another prisoner that she felt low and had thought about suicide and different methods of killing herself. An officer began ACCT procedures. Ms Hunt told an officer that she felt low with no family to turn to and her court case was looming. Later that day, Ms Hunt was moved to F Wing and began sharing a cell with another prisoner.
47. On 20 September, an officer assessed Ms Hunt, who said she had just been having a conversation about depression with a friend. She said she was upset that she did not have any contact with her daughter. She denied wanting to die and said she had no plans to kill herself. The officer noted in the ACCT document that Ms Hunt's court case was that week and this was a potential trigger for suicide or self-harm.
48. After the assessment interview, a SO held the first case review with an officer and Ms Hunt. The ACCT record indicates that a nurse was present but the SO said she did not think she was there. She said she had contacted the nurse to see if there was anything significant in Ms Hunt's medical record that she should know. She said she remembered that the nurse had confirmed that Ms Hunt was on antidepressants.
49. At the case review, the SO said Ms Hunt told her that she wanted to rebuild her relationship with her daughter and had written a letter to the judge before she appeared in court the next week. She said Ms Hunt seemed very focused on her court case. She did not remember her appearing particularly anxious or vulnerable and did not think it was necessary to continue ACCT monitoring until after her court appearance. Ms Hunt said she had no plans to take her life. The case review ended ACCT monitoring that day and she scheduled a post-closure review for 26 September.

50. On 21 September, Ms Hunt's cellmate told two officers that Ms Hunt felt like harming herself. The officers spoke to Ms Hunt, who denied this but said she felt depressed and anxious about her court case. One officer said that Ms Hunt appeared to be fine and not as bad as the cellmate had described. He said he and his colleague had considered beginning ACCT monitoring but, after talking to Ms Hunt, were reassured that this was not necessary. He said that as the cellmate was being monitored under ACCT procedures, he told the night patrol officer to keep an extra eye on Ms Hunt during the night.
51. The cellmate said she had met Ms Hunt during her first period at Foston Hall. She said that Ms Hunt was polite and kind and got on with the other women on the wing, but was depressed and worried about being sentenced and losing her house. She said Ms Hunt often talked about killing herself. When they started sharing a cell, she said that Ms Hunt told her that she had already written a suicide note to her daughter.

The night of 25 September 2015

52. On 25 September, Ms Hunt was convicted of breaching her suspended sentence. She was sentenced to nine months in prison for threats to kill and eight months for putting a person in fear of violence by harassment, to be served consecutively making a total of 17 months. Ms Hunt would have been eligible to apply for release on home detention curfew on 30 November 2015 and her automatic conditional release date was 7 April 2016.
53. A nurse saw Ms Hunt in the holding room when she arrived back from court. Ms Hunt said her life was over and she had nothing to live for. The nurse asked a SO, who was helping in reception, to begin ACCT procedures as she was busy with initial health assessments. Another SO completed the immediate action plan. Both SOs agreed that staff should observe Ms Hunt twice every hour.
54. The cellmate said Ms Hunt had thought she was going to court for a bail hearing and had expected to be released, as had happened the first time she was at Foston Hall. Her sentence had come as a total shock to her. When she got back from court, she told the cellmate that her life was over and she would not wake up in the morning. Ms Hunt said she would lose her house, everyone would be ashamed of her and there was no point continuing to live. The cellmate wrote a note for the night patrol officer and put it under the door. In the note she wrote:
- “Can you get me out of this room. My cell sharer is threatening suicide and am really scared. Don't speak to me in front of her.”
55. The cellmate said she heard the night patrol officer on F Wing collect the note. About half an hour afterwards, he came back to their cell and asked Ms Hunt if she was okay. Ms Hunt said she was fine. When he had gone, Ms Hunt took a plastic bag out of her wardrobe and put it on her bed. She then undressed and washed her face and said she was going to bed. The cellmate said it was unusual for Ms Hunt to go to bed so early and so abruptly.
56. The night patrol officer said that he and an officer (the outgoing day shift officer) had seen the note on the floor when they were checking Ms Hunt's landing during evening roll count at about 8.45pm. He said he picked it up and looked at

it, after he had walked a couple of doors down. He said the note was unsigned but the officer identified it as coming from Ms Hunt's cell. Ms Hunt's ACCT record indicates that she was walking about in her cell at this time.

57. Before he went home, the officer said he had telephoned the night manager, who told him that they should continue observing Ms Hunt twice an hour. The manager did not come to the wing or investigate the note further. The night patrol officer said he remembered the officer telephoning the night manager, who said that the level of observations should remain the same. He noted this in the wing observation book and stapled a copy of the note in the book.
58. During an internal prison investigation, the night manager denied that the officer had told him about the note. The prison suspended the night manager, who subsequently resigned. We have not spoken to him for this investigation.
59. At 9.20pm, the night patrol officer checked Ms Hunt. He noted in her ACCT record that she was sitting in a chair at the time. He told us that he had asked her if she was all right and she told him that she was.
60. The cellmate said she was lying on her bed reading when, about 10.00pm, she heard the rustling of a plastic bag. She then heard what sounded like Ms Hunt breathing into the bag. She said she got up and saw by the light coming from the bathroom that Ms Hunt was under the duvet. She went into the shower room and pressed the emergency cell bell so Ms Hunt would not see what she was doing. She said the night patrol officer came to the cell about ten minutes later. She told him that Ms Hunt had put a plastic bag on her head. He spoke to Ms Hunt, who said it was a conditioning treatment for her hair. When the cellmate said she had been breathing into it, Ms Hunt said she had been trying to prevent a panic attack.
61. The night patrol officer said he radioed the night manager and asked him to come to F Wing. He then asked the cellmate to keep an eye on Ms Hunt and went to the wing office to telephone the night nurses. He then went back to the cell and watched Ms Hunt until the night manager arrived.
62. The night patrol officer said the night manager arrived about 20 minutes later with staff. As Ms Hunt was not fully dressed, he said that the male staff stood outside the cell while the female staff went in.
63. Officer A said Ms Hunt was lying in bed. The cellmate told her that Ms Hunt had put a plastic bag over her head and she pointed to a large clear plastic bag used for transferring prisoner's property to and from court. Ms Hunt agreed that she had put the bag on her head but said it was to condition her hair. When the cellmate said she had heard Ms Hunt breathing into the bag, she again said that this was because she was having a panic attack. The officer asked Ms Hunt to get out of bed so the healthcare assistant could check her. They closed the door to give her some privacy.
64. The healthcare assistant checked Ms Hunt's pulse, blood pressure and oxygen levels. She said Ms Hunt seemed very agitated. Her pulse was slightly raised but her blood pressure was normal. She said she believed that Ms Hunt's agitation and her raised pulse was caused by the cellmate. She said that the

cellmate continually interrupted and contradicted Ms Hunt's answers to staff. The cellmate insisted that Ms Hunt had intended to kill herself by putting the bag over her head.

65. Officer A said she was aware that Ms Hunt was being monitored under ACCT procedures and had come back from court distressed about her sentence. She asked Ms Hunt if she felt suicidal and Ms Hunt said she was just tired. She said she had been out all day at court and she just wanted to go to sleep.
66. Officer A said she discussed the situation with the night manager and they decided to move Ms Hunt to another cell so she could get some rest. The cellmate then told them that Ms Hunt had written a suicide note, which was in her bag. The officer asked the cellmate to wait outside the cell.
67. Officer B found a letter addressed to Ms Hunt's daughter in Ms Hunt's bag. Officer A opened the letter and read it. Officer B said she thought she had "flicked through it" as well. She said she remembered that Ms Hunt was not allowed to contact her daughter and told Officer A.
68. The letter covered four sides of prison letter paper and began, "You are never going to see me again". Ms Hunt went on to say that she did not want to live any more and could not cope with the stigma of being in prison. She wrote about some issues she had had with her daughter and asked her daughter to give goodbye messages to various people and pets. There was nothing in the letter to indicate it had been written that night. Officer A said the letter set out for Ms Hunt's daughter why she had nothing left to live for.
69. Ms Hunt said she had written the letter some time before and knew she was not allowed to contact her daughter. She said it was how she had felt when she first arrived in prison. Officer A said Ms Hunt was adamant she was not suicidal and just wanted to go to sleep. The officers moved Ms Hunt to a cell on the landing below. The healthcare assistant said Ms Hunt visibly relaxed when she arrived at the new cell. She told Ms Hunt she would refer her to the mental health team the next morning. She said she did not think Ms Hunt was at high risk of suicide that night. She said she was agitated but that was normal for her. She said it was very hard to judge whether Ms Hunt had intended to kill herself with the plastic bag because it was very large and did not think it was an obvious method of suicide.
70. Officer B said she did not think Ms Hunt's risk was raised that night because she had seemed exactly the same as the other times she had spoken to her. She said Ms Hunt's overriding concern was to go to sleep. She had not read the ACCT document and did not know what Ms Hunt had said to the nurse when she returned from court.
71. Staff went to the wing office and reviewed Ms Hunt's situation. They agreed to increase observations to three times an hour. Officer A said she told the night patrol officer to radio her if he had any further concerns about Ms Hunt that night. The night manager recorded the review in Ms Hunt's document and noted that her risk was raised. He wrote, "Caroline has been putting plastic bags over her head and was caught by her cellmate. She had stated she wanted to end it all. After speaking with her we found a letter (attached) containing suicidal intent.

Move to F1-11 to give respite to cellmate and obs increased to 3x per hour until assessment”.

72. When he was interviewed for the internal investigation, the night manager said that the cellmate had alleged that Ms Hunt had attempted to harm herself by putting a plastic bag on her head. He said he regarded it as an allegation because no member of staff had witnessed it and Ms Hunt denied it. He said they had no evidence that Ms Hunt was actively preparing for suicide and she was insistent that she just wanted to sleep. The staff had agreed that Ms Hunt should be moved out of the cell with the cellmate so both women could rest. He said everyone had agreed that Ms Hunt’s risk was raised and that “to be on the safe side”, they should increase her checks to three an hour. He said they had considered other options, including moving Ms Hunt to a cell with another person or constantly supervising her, but they did not consider that her level of risk warranted either of those options.
73. The night patrol officer said he read the letter taken from Ms Hunt’s cell after the staff left him on the wing and was concerned about the content. He therefore decided to check Ms Hunt more frequently than specified during the night. This was reflected in the ACCT document. He said Ms Hunt slept throughout the night.

The morning of 26 September 2015

74. Officer C came on duty at about 7.25am. The night patrol officer told him that Ms Hunt had put a bag over her head during the night and had been moved to a single cell on increased observations. He told the officer that he was worried about Ms Hunt and asked him to keep an eye on her. At about 7.30am, they did the morning roll count together. The officer said Ms Hunt was asleep when they checked her.
75. At about 7.50am, Officer C checked Ms Hunt again, and noted in the ACCT document that she was awake and moving about her cell. As he was aware that the night patrol officer had been concerned about her, he went back to her cell at 7.58am, and saw her suspended by a sheet hooked over the internal shower room door. He radioed for immediate staff assistance and went into Ms Hunt’s cell. He lifted her body to release pressure on her neck and removed the sheet from around her neck. The control room asked him for an emergency code and he said it was a code blue, used to indicate situations such as when a prisoner is unconscious or is not breathing. He asked the control room to call an ambulance. A recording of the radio message shows that his original radio message was at 7.58am, he gave a code blue at 7.59am and the control room officer called an ambulance at 8.00am.
76. The custodial manager, who was orderly officer in charge of daily operations that morning, responded immediately. When he arrived at Ms Hunt’s cell, the officer was moving Ms Hunt onto the bed. He advised him to move her to the floor and begin chest compressions.
77. More staff arrived quickly. The healthcare assistant brought an emergency bag containing oxygen and a defibrillator (a life-saving device that gives the heart an electric shock in some cases of cardiac arrest). A SO helped Officer C move Ms

Hunt into the centre of the cell to give more room and took over chest compressions. At 8.02am, the custodial manager instructed the control room to open the gates and direct the ambulance to the nearest entrance to F Wing.

78. The nurses attached the defibrillator and gave Ms Hunt oxygen. The defibrillator checked Ms Hunt periodically but found no shockable heart rhythm and advised continuing chest compressions. Paramedics arrived at the prison gate at 8.15am. They went to Ms Hunt's cell, took over emergency treatment and administered adrenaline. Paramedics asked the prison nurses to continue chest compressions while they completed their procedures. At 8.36am, paramedics detected a pulse but Ms Hunt was not breathing independently. At 8.51am, Ms Hunt was taken to hospital.
79. The senior manager on duty telephoned Ms Hunt's cousin, who she had named as her next of kin, to tell her what had happened. However, her cousin was away from home. She asked the police for help and they contacted her cousin and also said that they would arrange to inform Ms Hunt's daughter, as she was the victim of her crime.
80. That day, Derbyshire police asked West Midlands police to send someone to tell Ms Hunt's daughter that her mother had been taken to hospital. Ms Hunt's daughter said this did not happen. She said she first heard that her mother was in hospital when Derbyshire police telephoned her on 27 September to update her. The senior manager telephoned Ms Hunt's daughter on 28 September.
81. Ms Hunt's cousin decided that she did not want to act as Ms Hunt's next of kin. The senior manager offered to help Ms Hunt's daughter to visit her mother in hospital but she said she needed to think about it.
82. Ms Hunt died at 10.16am on 29 September without regaining consciousness. At her daughter's request, the senior manager informed her of her death by telephone and also telephoned Ms Hunt's cousin to break the news. The prison contributed to the costs of Ms Hunt's funeral in line with national policy.

Support for prisoners and staff

83. After Ms Hunt was taken to hospital on 26 September, the senior manager debriefed the staff involved in the emergency response to offer support, discuss any issues arising and offer the support of the staff care team.
84. The prison posted notices, informing other prisoners of Ms Hunt's death and offering support. Staff reviewed all prisoners assessed as at risk of suicide and self-harm, in case they had been adversely affected by Ms Hunt's death. The two prisoners we interviewed said they had received good support, although the cellmate believed it should have been given sooner.

Post-mortem report

85. The post-mortem examination concluded that Ms Hunt died from hypoxic brain injury resulting from hanging. Toxicological tests for non-prescribed drugs and alcohol were negative.

Findings

ACCT procedures

86. Prison Service Instruction (PSI) 64/2011 (Safer Custody) which gives guidance on how to manage suicide and self-harm procedures, lists a number of risk factors and potential triggers for suicide and self-harm. Ms Hunt had a number of these risks during her second period in Foston Hall between 9 and 26 September including:
- violent offence against a family member;
 - further charges;
 - court appearances (especially at sentencing);
 - longer sentence than expected;
 - hopelessness;
 - suicidal ideation;
 - lack of social support;
 - family relationship breakdown; and
 - history of depression.
87. Staff appropriately began ACCT procedures when Ms Hunt arrived on 9 September. She had a suicide and self-harm warning form from court after repeatedly saying she intended to kill herself. A reception nurse found she was anxious and distressed and said she planned suicide.
88. Prison Service Instruction (PSI) 64/2011 requires first case reviews to be held within 24 hours of the start of ACCT procedures, but this did not happen until 36 hours later, on 11 September, two days after Ms Hunt had arrived at the prison. This was apparently because the assessment interview did not take place until the evening of 10 September. Ideally, first ACCT case reviews should take place immediately after the assessment. We recognise that it might have been difficult to organise a full multidisciplinary review at that time, but in the event, there was no multidisciplinary review.
89. PSI 64/2011 requires ACCT case reviews to be multidisciplinary where possible, involving staff from relevant departments and services. It is a mandatory requirement that a member of healthcare staff should attend first case reviews. On 11 September, a SO held Ms Hunt's first case review with no other member of staff present. Even when multidisciplinary attendance is not possible, it is implicit that ACCT case reviews, which should be based on teamwork, involve more than one member of staff, and this is poor practice. We are concerned that the SO assessed Ms Hunt's risk as low, although she had cut her wrists just the day before, had said she planned to kill herself, and had a range of other risk factors for suicide.
90. Multi-disciplinary reviews should help facilitate effective communication between departments. On 16 September, a prison GP and a nurse were both concerned about Ms Hunt's state of mind. The GP prescribed antidepressants and referred her for to the mental health team for counselling. No one from the healthcare team was present at the review later that afternoon when staff ended ACCT procedures. This meant that the staff taking the decision had no access to Ms

Hunt's medical records and were unaware of the concerns the nurse and the GP had about her. There is no evidence that they sought any input from healthcare staff, as they should have done.

91. It is also a mandatory requirement of PSI 64/2011 that prisoners' ACCT documents accompany them within the prison so that all staff are aware of the identified risks and are able to update the ongoing record. Neither the nurse nor the GP wrote anything about their concerns in Ms Hunt's ACCT record, as should have happened. Entries for the corresponding times in the ACCT record suggest that the record was not with Ms Hunt when she saw the nurse and GP. Again, this meant that staff at the ACCT case review that day, were unaware of their concerns.
92. The national instructions say that an ACCT must not be closed until all the caremap actions have been completed and the review team is satisfied that the prisoner's risk has reduced. Ms Hunt had four caremap actions – about housing, depression, education and her court case. Although she had applied for help with a housing issue, this had not yet been resolved and her court case was yet to take place, so neither of these actions were complete. Ms Hunt had just been prescribed antidepressants at lunchtime that day. There is no evidence on the record to indicate how staff concluded that Ms Hunt's risk had reduced.
93. Another ACCT was opened on 19 September, after Ms Hunt said she felt low, had no family support and her court case was imminent. "Court case this week" was added to the risks and triggers page. Despite this, the ACCT was closed at the first review the next day, without a caremap being completed and despite this previously identified trigger remaining. Again, the case review was not multidisciplinary. Although a nurse was listed as attending, the SO, who chaired the review, did not think she was there.
94. It is clear from the moment Ms Hunt returned to Foston Hall on 9 September, that she was extremely anxious about her court case, afraid that she would lose her house and believed she would be ostracised in the community if she received a prison sentence. We consider that Ms Hunt should have been managed under ACCT procedures continuously, at least until after her court case. Her risk could not have been reduced until the outcome was known. When she received a prison sentence, it was likely that her risk would have increased considerably. We are concerned that staff did not operate ACCT procedures effectively to protect and support Ms Hunt. We make the following recommendation:

The Governor should ensure that staff manage prisoners at risk of suicide or self-harm in line with national guidelines. In particular:

- **Staff should hold multidisciplinary case reviews attended by all relevant people involved in a prisoner's care. A member of healthcare staff should attend all first case reviews.**
- **Case reviews should consider all known risk factors when determining the level of risk of suicide and self-harm, and set levels of observations which reflect the risk.**
- **Case managers should set ACCT caremap actions and review progress against caremaps at each review and not close ACCT plans until all caremap actions have been completed.**

Assessing Ms Hunt's risk on 25 September

95. Staff began ACCT monitoring again on 25 September when Ms Hunt returned from court after receiving a prison sentence. Ms Hunt told a nurse that her life was over and she had nothing to live for. Two supervising officers in reception set levels of observations at twice an hour. As with previous periods when Ms Hunt was monitored under ACCT procedures, we are concerned that staff underestimated her level of risk.
96. Later that night, the cellmate told officers that Ms Hunt was suicidal. Ms Hunt admitted putting a plastic bag on her head and breathing into it. Her explanation for this was unconvincing and the staff should have regarded this as an active suicide attempt. In addition, officers read a letter Ms Hunt had written to her daughter in which she spoke about her life being over and having lost everything. In conjunction with what she had said earlier, when she had first arrived back from court, this should have indicated a high risk of suicide. Ms Hunt had repeatedly said she would not be able to bear a prison sentence, had nothing to live for and intended to kill herself.
97. Staff judgement is fundamental and the ACCT system relies on staff using their experience and skills, as well as local and national assessment tools, to determine risk. However, none of the staff who had contact with Ms Hunt on the night of 25/26 September (apart from the night patrol officer after he had read Ms Hunt's letter), considered her at high risk of suicide, despite the range of her risk factors, her statement to the nurse that her life was over, her admission that she had put a plastic bag over her head, evidence from the cellmate about her suicidal ideation and her history of anxiety about receiving a prison sentence.
98. While a prisoner's presentation is obviously important and reveals something of their level of risk, it is only one piece of evidence in judging risk. Staff should make a considered, objective evaluation of all risk factors when assessing the risk of suicide and self-harm and document their decision. The night manager had noted that Ms Hunt had been putting plastic bags over her head, had stated that she wanted to end it all and had written a letter containing suicidal intent. Despite this, he moved Ms Hunt to a single cell on her own with observations increased from two to three times an hour.
99. The night manager told the internal prison investigator that he and the other staff had considered other options such as moving Ms Hunt to a cell with another woman or whether she should be constantly supervised. However, there is no record of any consideration of these alternatives or why they were discounted. None of the staff we interviewed recalled any suggestion of constant supervision. Officers A and B did not appear to recognise that Ms Hunt was at real risk of suicide. However, PSI 64/2011 indicates that when reviewing risk, staff should consider constant supervision in cases including when there have been serious attempts and/or compelling preparations for suicide, writing a suicide note and a credible expression of a wish to die. All these factors applied.
100. There is little evidence that anyone fully considered the implications of a prison sentence for a woman with no criminal history, no family support and the likelihood of losing her house. When she returned from court, she said she had nothing to live for. Ms Hunt admitted to putting a bag over her head and did not

offer credible reasons why she had done this. Although she might not have written the letter to her daughter that night, the sentiment within it was one of hopelessness and envisaged no future. We consider that there was significant evidence that Ms Hunt was at high risk of suicide after receiving her prison sentence. While we recognise that making such judgements is difficult, ultimately, all of the staff relied too much on Ms Hunt's subsequent denials of suicidal intent. We make the following recommendation:

The Governor should ensure that staff fully consider all additional information when further reviewing the risk of prisoners already assessed as at risk of suicide or self-harm. Constant supervision should be considered when indicated, in line with the guidance in PSI 64/2011 and all options that were considered, but discounted, should be recorded in the ACCT document.

Management of Ms Hunt's healthcare

101. In his review, the clinical reviewer noted that Ms Hunt was not reviewed by the mental health team at Foston Hall despite her self-harm, frequently expressed suicidal thoughts and diagnosis of anxiety and depression. He commented that no one linked the symptoms observed during the period she was being monitored for symptoms of alcohol withdrawal, such as fidgeting and nervousness, with underlying anxiety and depression. He considered that Ms Hunt's care was not equivalent to other NHS patients with similar healthcare needs in the community.
102. We expect that every prisoner identified as being at risk of suicide and self-harm should have a full mental health assessment, especially when the prisoner has been diagnosed with anxiety and depression. While we cannot say that a full mental health assessment would have prevented Ms Hunt's death, this was a missed opportunity to assess her risk to herself and offer her further support. We make the following recommendation:

The Governor and Head of Healthcare should ensure that the prisoners identified as at risk of suicide and self-harm are referred urgently for a prompt mental health assessment.

Emergency response

103. Prison Service Instruction (PSI) 03/2013 requires prisons to have a medical emergency response code protocol that ensures that an ambulance is called automatically in a life-threatening medical emergency. Officer C did not use a medical emergency code when he first radioed for help after finding Ms Hunt had hanged herself. Staff need to be fully aware of the emergency code system, as any delay can be crucial. However, we recognise that this was a shocking situation for him and he radioed for help straight away. The control room officer then asked him for a code and called an ambulance immediately. We are satisfied that there was no delay in communicating the nature of the emergency and calling an ambulance.

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