

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Ms Sarah Reed a prisoner at HMP Holloway on 11 January 2016

**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.

Tragically, Sarah Reed was found dead with ligatures around her neck in her cell at HMP Holloway on 11 January 2016. Ms Reed was 32 years old. I offer my condolences to Ms Reed's family and friends.

Ms Reed suffered from serious mental health problems and had been in both prison and mental health hospitals in the past. On 14 October 2015, she was remanded in custody to Holloway. In November, after she complained of chest pain, doctors altered her mental health medication. In December and January, Ms Reed's mental health deteriorated and the prison healthcare team initiated the process to have her assessed for transfer to a secure hospital in the community.

The clinical reviewers noted that, because of Ms Reed's complex mental health and behavioural issues, it was not possible to judge whether the standard of her overall care in Holloway was equivalent to that she could have expected to receive in the community. While there were some deficiencies in monitoring her health, these were exacerbated by Ms Reed's refusal to engage with healthcare services. On the two key questions of whether Ms Reed should have been prescribed anti-psychotic medication in late December 2015 and early January 2016, and whether the prison was timely in referring her for transfer to hospital, the clinical reviewers were satisfied that these issues were given proper consideration.

While prison staff may not have been able to predict Ms Reed's actions, her mental health had been noticeably deteriorating over the previous fortnight and there were a number of weaknesses in the way her risks were managed, not least the failure to involve her family in her care. There were, however, no immediate indications that she was in danger of taking her own life in the days leading up to actually doing so.

This is a particularly troubling case of a seriously unwell woman being held in a prison setting which, despite commendable efforts by some staff, proved incapable of keeping her safe. It is essential that lessons are learned from Ms Reed's tragic case. Accordingly, although Holloway prison has now closed, I make a number of generic recommendations to the National Offender Management Service.

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**

**January 2017**

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# Summary

## Events

1. On 14 October 2015, Ms Sarah Reed was remanded to HMP Holloway charged with wounding with intent. At the hearing, the court asked for a psychiatric report to assess whether she was fit to plead. Ms Reed had a history of mental health problems and drug use, and had been in Holloway before.
2. At an initial health screen, a nurse was concerned about Ms Reed's thought processes, behaviour and history of self-harm. She therefore began Prison Service suicide and self-harm prevention procedures, known as ACCT. Staff continued to monitor Ms Reed under ACCT procedures until early November.
3. Prison doctors were concerned that Ms Reed was on a high level of medication. On 15 November, she was taken to hospital with chest pain. When she was discharged back to the prison, the hospital consultant advised that her mental health medication be discontinued as it was placing too much of a strain on her heart. Prison doctors stopped prescribing this medication but Ms Reed became anxious at the prospect of not receiving it.
4. In December, Ms Reed's mental health and behaviour began to deteriorate. She was moved to the prison's segregation unit and, when she wrote in a letter that she was thinking of harming herself, staff began ACCT monitoring procedures again. On 5 January 2016, she was admitted to the prison's mental health unit for observation. Healthcare staff began the process to assess her for transfer to a secure hospital under the Mental Health Act.
5. Ms Reed's mental health deteriorated further and her behaviour became erratic and unpredictable. She spent long periods shouting, chanting, and making noises in her cell. She threatened staff and other prisoners. Staff placed a screen in front of her door because she was spitting at people as they passed. Managers decided that four prison officers were required to unlock Ms Reed's cell.
6. On the morning of 11 January, prison officers and a nurse went to Ms Reed's cell to give her breakfast and medication. They found her lying unresponsive on her bed with a torn bed sheet around her neck. The staff called an emergency code and tried to resuscitate her. Paramedics arrived and pronounced Ms Reed dead.

## Findings

### *Healthcare*

7. Ms Reed had an extensive healthcare history that covered several years. Her diagnoses and clinical explanations for particular conditions were not always clear. This sometimes made it difficult for healthcare staff in Holloway to judge how best to treat her. In addition, Ms Reed did not always cooperate with medical staff.
8. The clinical reviewers noted that the decision to stop Ms Reed's quetiapine when she suffered chest pain was reasonable. They were also content that

consideration of Ms Reed's medication was reasonable. They also noted that Ms Reed was appropriately monitored throughout late December and early January and considered that the plans made to transfer her to a secure hospital when her mental health began to deteriorate were reasonable.

#### *ACCT management*

9. Ms Reed was managed under ACCT procedures (Prison Service monitoring of prisoners thought to be at risk of suicide or self-harm) on two occasions while in Holloway. There were some problems around continuity of case management and with prison staff maintaining the ongoing record, issues which we have raised with Holloway in the past. We are concerned that risk assessments did not seem to be in line with how Ms Reed was presenting, her care map was not well used, and the appropriate procedures were not followed when Ms Reed was housed in the prison's segregation unit.

#### *Contact with Ms Reed's family*

10. We are concerned that Ms Reed's family was not involved in the ACCT process and also note that her family was unable to raise concerns about Ms Reed's wellbeing with the prison. Attempts to visit her in prison were frustrated by Holloway on several occasions, sometimes at the last minute, without any clear justification for doing so. When Ms Reed died, Prison Service guidelines were not followed in breaking the news to her family and the information provided initially was misleading.

#### *Incentives and Earned Privileges scheme (IEP)*

11. Holloway's violence reduction policy stated that when managing poor behaviour by prisoners with mental health issues under the IEP, the mental health team should be consulted, and this process documented. There are no indications in Ms Reed's records that they were consulted when Ms Reed was placed onto the basic IEP regime, as she frequently was.

#### *Bullying*

12. Ms Reed informed officers that she was being bullied on several occasions although she would not say by whom. She did not make any complaints about particular officers. Although Holloway's violence reduction policy stated that where bullying is suspected, perpetrators should be challenged and victims asked for their account of what happened, there are no indications that anyone asked Ms Reed who was bullying her.

### **Recommendations**

- NOMS should ensure that prisons manage prisoners subject to ACCT procedures in line with national policy, including:
  - Mental health staff attend or contribute to all ACCT reviews for prisoners with mental health issues, and are fully involved in decisions about their level of risk;
  - Setting levels of observations which are appropriately adjusted as the perceived risk changes;

- Recording ACCT observations immediately or as soon as possible after they are made;
  - Effective caremap objectives are set that are specific and meaningful, aimed at reducing risk and updated at each case review;
  - Prisoners assessed as at risk of suicide or self-harm are not held in the segregation unit unless all other options have been considered and excluded, and there are fully documented reasons to explain the exceptional circumstances.
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- NOMS should ensure that ACCT case managers are aware that they should give proper consideration to involving the prisoner's family in the ACCT process and record this in the ACCT plan.
  - NOMS should ensure that prisoners' families wanting to express concerns about the wellbeing of a prisoner are able to do so.
  - NOMS should ensure that prisoners who are frequently penalised under the incentives and earned privileges scheme are assessed for a behaviour management plan.
  - NOMS should ensure that, where possible, a member of staff informs a prisoner's family in person of their death, in line with national instructions.
  - NOMS should ensure that staff breaking news to bereaved families provide as accurate information as possible.

## The Investigation Process

13. The investigator issued notices to staff and prisoners at HMP Holloway informing them of the investigation and asking anyone with relevant information to contact him. He received three responses.
14. The investigator visited Holloway on 15 January. He obtained copies of relevant extracts from Ms Reed's prison and medical records.
15. The investigator interviewed nine members of staff and seven prisoners. He also interviewed Ms Reed's mother, and received information from Ms Reed's family. He was unable to speak to two other prison officers who had left Holloway and moved on elsewhere, despite giving them repeated opportunities to be interviewed.
16. NHS England commissioned clinical reviewers to review Ms Reed's clinical care at the prison. One of the clinical reviewers conducted joint interviews of medical staff with the investigator.
17. We informed HM Coroner for the City of London of the investigation and sent him the results of the post-mortem examination. We have given the coroner a copy of this report.
18. One of the Ombudsman's family liaison officers contacted Ms Reed's mother, to explain the investigation and to ask if she had any matters the family wanted the investigation to consider. She and the investigator met Ms Reed's mother, other members of her family and friends, together with their solicitor and media representative to discuss the matters they wanted to raise. Ms Reed's family had a number of questions.
  - Given Ms Reed's long-term health issues, did healthcare staff in Holloway communicate with the outside agencies which cared for Ms Reed?
  - Did Ms Reed receive the correct medication while in Holloway?
  - Ms Reed, being bulimic, had in the past had her potassium levels monitored and, when necessary, had potassium administered intravenously. Was she in need of extra potassium? Were her potassium levels checked?
  - Was it appropriate for Ms Reed to be in prison or should she have been moved to a secure hospital?
  - Was there evidence that Ms Reed was being bullied by other prisoners?
  - When Ms Reed was remanded, the court directed that a psychiatric assessment was required. Had this been completed?
  - Did Ms Reed have a physical altercation with prison officers the night before she died?
  - How did she take her own life?
19. Solicitors representing Ms Reed's family received a copy of the initial report. In response to their comments we have made some minor amendments to wording in the report at paragraphs 38, 99 and 130. Other points they raised have been addressed in separate correspondence.

# Background Information

## HMP Holloway

20. HMP Holloway closed in 2016. At the time of Ms Reed's death, Holloway was a prison for women in north London which served courts across the south east of England. It held approximately 500 women in single and double cells and multi-occupancy dormitories. Central & North West London NHS Foundation Trust provided healthcare services. C1 was the mental health assessment unit. Nurses were on duty at Holloway 24 hours a day.

## HM Inspectorate of Prisons

21. The last inspection of Holloway was carried out in October 2015. Inspectors reported that the prison was generally safe and well controlled and that formal disciplinary procedures were well managed and used as a last resort. Relationships between staff and prisoners were good, and some members of staff working with more complex and challenging prisoners were described as exceptional. Managers and most staff placed decency and respect for the individual at the centre of their work. However, many women reported feeling unsafe on occasion. There were also unacceptable delays moving women with mental health problems to secure hospital beds but inspectors found that support for vulnerable women, including those with very complex needs, was very good.

## Independent Monitoring Board

22. 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 last annual report, for the year to 31 December 2015, the IMB was very concerned about the number of women with serious mental health needs who were being held in the prison. The IMB noted that the severe shortage of high and medium secure psychiatric beds in hospital continued to make it very difficult for women requiring hospital treatment for mental illness to be transferred out of Holloway. It was concerned that the closure of Holloway would mean that many mentally ill women currently cared for in C1, the mental health assessment unit at Holloway, would end up being housed in segregation units in other prisons.
23. In a supplementary report covering the period from January to Holloway's closure in June 2016, the IMB noted that healthcare provision, including the operation of C1, the prison's mental health wing, continued right up to closure. It stated that transfers to mental health hospitals were well managed.

## Previous deaths at HMP Holloway

24. Ms Reed's was only the second self-inflicted death in Holloway since 2007. In our report of the investigation into the last death, in 2014, we recommended that prison staff should record ACCT observations as soon as possible after they were made. This was also an issue in this investigation.

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

25. ACCT is the care-planning system the Prison Service uses to support prisoners at risk of suicide or self-harm. The purpose of the ACCT is to try to determine the level of risk posed, the steps that staff might take to reduce this and the extent to which staff need to monitor and supervise the prisoner. Checks should be done at irregular intervals to prevent the prisoner anticipating when they will occur. Part of the ACCT process involves assessing immediate needs and drawing up a caremap to identify the prisoner's most urgent issues and how they will be met. Staff should hold regular multidisciplinary reviews and should not close the ACCT plan until all the actions of the caremap are completed. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011 *Management of prisoners at risk of harm to self, to others and from others (Safer Custody)*.

## Segregation units

26. Segregation units are used to keep prisoners apart from other prisoners. This can be because they feel vulnerable or under threat from other prisoners, or if they behave in a way that prison staff think would place other people in danger or cause difficulties for the rest of the prison. They also hold prisoners serving punishments of cellular confinement after disciplinary hearings. Segregation is authorised by an operational manager at the prison who has to be satisfied that the prisoner is fit for segregation after an assessment by a member of healthcare staff. Segregation unit regimes are usually restricted and prisoners are permitted to leave their cells only to collect meals, shower, make phone calls and have a daily period in the open air. A manager, a member of the chaplaincy team and a member of the healthcare team should visit the segregation unit daily and speak to each segregated prisoner to check on her welfare. A doctor should visit at least every three days and a registered nurse on the other days to assess the physical, emotional and mental well being of the prisoner and whether there are any apparent clinical reasons to advise against continuing segregation.

## Incentives and Earned Privileges (IEP) scheme

27. Prison IEP schemes aim to encourage and reward responsible behaviour through the award of greater privileges where a prisoner has been compliant with the prison regime and has engaged in work, education or other constructive activity. Similarly, these privileges can be removed if her behaviour deteriorates. There are four regime levels:
- Entry regime - new prisoners begin on this level;
  - Basic regime - the lowest ranking with the least level of privileges;
  - Standard regime;
  - Enhanced regime – the highest level.

# Key Events

## Reception

28. On 14 October 2015, Ms Reed was remanded to HMP Holloway, charged with wounding with intent. The court had requested a psychiatric report to help it decide whether Ms Reed was fit to plead at trial. Ms Reed had been in prison before, including at Holloway. Her records showed that she had a history of self-harm, problems with drug misuse and could be violent. She had suffered from mental health problems and was under the care of the South London and Maudsley NHS Foundation Trust. The escort papers that arrived with Ms Reed at Holloway did not identify any imminent risks. At a basic custody screen (intended primarily to identify her immediate needs) Ms Reed said she had good support from family and friends. She was assessed as being too high risk to share a cell and was therefore allocated a single cell.

## *Physical health*

29. At her initial health screen, Ms Reed tested positive for cocaine, benzodiazepine and opiates. Ms Reed told a nurse that she was prescribed quetiapine (an antipsychotic drug also used to treat depression), promethazine (used to treat a number of symptoms including psychosis, pain, nausea and anxiety), clonazepam (for seizures and panic disorders), haloperidol (an antipsychotic), fluoxetine (an antidepressant), and zopiclone (for insomnia). She admitted drug and heavy alcohol use, and was on a methadone programme for opiate dependency.
30. The prison obtained confirmation of Ms Reed's prescribed medication. A nurse noted a family history of ischaemic heart disease and schizophrenia; that a care plan had been produced; and that Ms Reed would need to move to C1 to manage her mental health problems. The nurse also created an alcohol detoxification plan. Another nurse spoke to one of the prison doctors, querying the prescription of Clonazepam, as it was unclear why it had been prescribed. The doctor advised that she should begin a course of diazepam, gradually reducing as she completed her alcohol detoxification programme. Another nurse said that the psychiatrist would need to consider Ms Reed's haloperidol prescription.

## *Mental health*

31. In June 2015, while at HMP Bronzefield, Ms Reed had said that she was not getting the mental health medication she needed and was having thoughts and hallucinations about being attacked by demons. On arrival at Holloway, she said that a nurse from the South London and Maudsley Trust was her community psychiatric nurse, and that she had been detained in hospital under the Mental Health Act two months previously. She had no current thoughts of harming herself but had cut her throat eight weeks previously. She was hearing voices, and asked to be housed on C1, the prison's mental health unit. A nurse referred Ms Reed to the mental health team for assessment. A social worker requested of the community psychiatric nurse Ms Reed's background information and an update on her mental health since she had last been in Holloway. On 29

October, Ms Reed moved to C1 wing, the prison's mental health wing, for assessment.

### *ACCT*

32. At the reception health screening a nurse was concerned about Ms Reed's thinking and behaviour, and began ACCT suicide and self-harm prevention procedures. At an ACCT review, Ms Reed said she had started to feel unwell and suicidal. Voices and hallucinations had told her to harm herself or others, but she was not planning to act on these voices.

### **14 October to 14 December**

#### *Physical health*

33. The South London and Maudsley Trust provided the prison with Ms Reed's medical history. The email included notes from her last review on 29 September, when she had appeared to be over-sedated and seemed to be very reliant on her medication. In November, a nurse spoke to Ms Reed about her eating habits. When she was last in prison her potassium levels had been dangerously low because of self-induced vomiting. Ms Reed said she vomited after most meals, although staff had not witnessed this.
34. During the evening of Saturday 14 November, Ms Reed reported pain in her chest, similar to when her potassium levels had previously been low. She refused to take her medication before dinner and, after dinner, had made herself vomit. Later that evening, she said that the pain in her chest had increased, and she was taken by ambulance to hospital. She stabilised overnight and the following morning saw a heart specialist. He considered that the combination of Ms Reed taking methadone and quetiapine with vomiting after eating meals was causing abnormal ECG results. He advised that Ms Reed should stop taking quetiapine until a psychiatrist was able to consider an alternative antipsychotic medication. She returned to Holloway that afternoon.
35. The prison psychiatrist told her that it was not safe for her health to take quetiapine at that time. She said that even before Ms Reed had gone to hospital with chest pains the medical team had been considering stopping quetiapine as it did not appear to be clinically necessary. She noted that Ms Reed was reasonable about what she was told but asked for an alternative prescription. The doctor noted that nursing staff should continue to explain to Ms Reed why using antipsychotic medication was not an appropriate solution, and that she should try other approaches, such as psychological treatments. An ECG test disclosed no serious abnormalities. On 18 November, a multidisciplinary healthcare meeting agreed that Ms Reed's cardiac problems meant that she should not be given any psychotropic medication at that time. The mental health team was to follow up assessments of her mental health.
36. On 9 December, Ms Reed told a nurse from the mental health team that she was unable to sleep and that she induced vomiting after every meal. The nurse told her that she was waiting for Ms Reed's consultant in the community to provide a date to discuss her medication. Ms Reed said that she was hearing voices, and

was being bullied by other prisoners who were calling her a paedophile because of the nature of the thoughts she was having about children.

### *Mental health*

37. On 22 October, the mental health nurse assessed Ms Reed. Ms Reed was calm, but seemed sedated and distracted. She had been remanded having been charged with assaulting a nurse, and said she did this because the nurse and a friend were planning to kill her. She maintained eye contact and articulated well, and said that she was having unwelcome sexual thoughts about children. This had happened in the past. She said that the prisoner in the next cell had been calling her a paedophile, and Ms Reed had threatened to assault her if she continued to do so. Ms Reed said that one of the prison officers on her wing did not like her, and had given her a behaviour warning. She felt low in mood, unsafe on the wing, and was not receiving the medication she had been given in the community. Ms Reed said that her bulimia was not too bad at the time, and she was eating and sleeping, but that she hallucinated after vomiting. The nurse noted that Ms Reed was on a particularly high dose of medication, and above the usual maximum dose for antipsychotic medication. She recorded that Ms Reed's psychiatrist in the community and the prison psychiatrist should discuss her medication.
38. Ms Reed's medical file shows that she was unstable in mood, unpredictable and sometimes aggressive, although there was no suggestion that she had acted on any feelings of self-harm. She was agitated and her behaviour was deteriorating. On 28 October her mental health care plan noted that, although she said she was hearing voices, psychosis had been ruled out. When she moved to C1, she was more settled, although she was drowsy and slow after taking her medication, and often appeared over-sedated. She threatened, however, to harm herself if her medication was reduced. The medical team agreed that reduction would have to be part of an organised plan. A prison GP told Ms Reed on 5 November that he would like to reduce her prescriptions of diazepam and quetiapine. Ms Reed asked him to postpone this for three days but he said that based on how she was presenting he thought it needed to be done that day. He explained that if she was sedated during the day this would most likely disrupt her sleep at night, causing her to sleep during the day and disrupt her sleep pattern. Eventually, Ms Reed accepted a reduction.
39. On 9 November, Ms Reed told a prison GP that she had felt well since her medication had been reduced but had been having bad dreams. He noted that none of her symptoms indicated depression, delusion or psychosis, and that she did not report any thoughts of harming herself or others. He decided that her psychotropic medication should be reduced again, and that she should remain on C1 so that nurses could assess her mental state during the reduction.
40. On 10 November, Ms Reed asked a prison GP to return her quetiapine prescription back up to its previous dose. She said that she was starting to feel "funny", although could not explain it any further. She said she was also having thoughts and feelings that she found intolerable. The GP said that being sedated was not good for her in the long-term but Ms Reed denied being sedated and said that she was not sleeping. A multidisciplinary healthcare team considered

Ms Reed's medication. She had said that she did not want her quetiapine reduced and said that she was struggling to cope with all her feelings. The meeting agreed not to reduce her quetiapine any further until she was able to attend therapy groups.

41. When Ms Reed returned to Holloway after going to hospital with chest pains, she said that she did not want to stop taking quetiapine (which had been discontinued by the heart specialist at hospital) as she was worried she would be unable to sleep. Staff told her that her heart was more important, and she would require further tests before anyone could take a decision about restarting on quetiapine. Ms Reed's mental health care plan noted that she should have her blood checked for potassium levels.
42. An intelligence report dated 12 December noted that Ms Reed had written a letter in which she had threatened to assault prisoners and to slit her own throat. The report noted that her behaviour had been deteriorating. She had been shouting and screaming on the wing, and making threats to assault staff and prisoners. They referred the intelligence to the mental health team.

#### *Custodial behaviour*

43. Ms Reed's record shows that she caused some problems with her behaviour. On 15 October, Ms Reed argued with a group of prisoners and fought with one of them. Later that week, officers had to warn her about misusing her cell call bell. A few days later, she had a fight with another prisoner. An intelligence report noted that Ms Reed might have been bullying another prisoner.
44. On 29 October, Ms Reed moved to C1 unit for assessment and settled well, although a note on her record showed that she did not interact much with other prisoners and looked unkempt. Nevertheless, she was pleasant and displayed no aggression, or volatile or inappropriate behaviour. Within days, however, her behaviour became more challenging. Staff warned her twice about eating food on the landing, which was not allowed. After she spoke to another prisoner, officers noted the other prisoner asked to be locked in her cell early. Ms Reed tried to keep her coat on when asked to remove it during a search. For safety's sake, prisoners in C1 are not allowed their own lighters and are offered a light once an hour. Ms Reed frequently asked officers for a light outside this time and the officers noted that she was trying to test the boundaries of acceptable behaviour. A prison officer overheard Ms Reed asking another prisoner for sugar and explained that prisoners on C1 were not allowed to ask each other for any items. A short time later, the same officer heard Ms Reed asking another prisoner for cigarette papers and, when she told Ms Reed that she had already warned her about this, Ms Reed became very agitated and threatened the officer.
45. On several occasions, Ms Reed caused problems with other prisoners. Officers saw her harassing another prisoner, asking her for items. The prisoner asked to be locked into her cell. Ms Reed then became angry at a prison officer, and began screaming abuse and threats at her. She had to be told not to misuse her cell bell several times. On one occasion officers locked Ms Reed in her cell early as she was causing problems with other prisoners, asking them for things despite being told to stop doing so, and whispering to others, causing friction during a group session. From inside her cell, Ms Reed then screamed and shouted

threats and abuse at staff, threatening to throw boiling water on them. Staff judged that it was only safe to unlock her when there were three officers present (a three-officer unlock) and she was not allowed any hot water. In mid-November, another prisoner told officers that Ms Reed had told her not to take her medication, and that she was going to be beaten up. The other prisoner was very upset and nurses had to persuade her to take her medication. On 18 November, Ms Reed had a fight with another prisoner and had to be restrained and taken back to her cell.

46. During the night, officers had to warn her about shouting obscenities and ringing her cell bell. During the day, she shouted and screamed for no apparent reason. When an officer introduced herself to Ms Reed as her personal officer (a named individual intended to be the first person to turn to for any queries or problems), she noted that Ms Reed refused to listen and was argumentative and insulting.
47. On 3 December, Ms Reed had an altercation with two other prisoners in the exercise yard. On 9 December, she had an argument with another prisoner, and shouted and swore at prison staff who intervened. She was moved to a different wing.
48. These discipline problems were mainly addressed through the incentive and earned privileges scheme (IEP), and Ms Reed spent periods on the scheme's basic level. On one occasion, she threatened the prison officer who gave her the warning and staff decided that, in view of the perceived risk involved, there should still be at least two officers present whenever her cell was unlocked. On one occasion she refused to attend a disciplinary hearing and was moved to the segregation unit. She was due to have a visit from her partner that day but the prison cancelled it.

### *ACCT*

49. Ms Reed was managed under ACCT procedures until 5 November. She attended and engaged with reviews, even if sometimes her medication had made her drowsy. Initially, she reported that she felt like harming herself, although she would not say why, but that she was working with the mental health team, who were generally represented at the reviews. She found the confidential Samaritans telephone, to which prisoners have access, helpful. Ms Reed sometimes told reviews that she did not have thoughts of harming herself, and sometimes that she did but had no intention to act on these thoughts. Her risk of self-harm was generally assessed as low. When she moved to C1 unit at the end of October, the unit manager held a review to ensure that the change had not unsettled her.
50. When staff held an ACCT review on 5 November, Ms Reed engaged well, and said she felt better and more relaxed. She appeared drowsy, although the nurse present said this was normal for prisoners taking methadone. Ms Reed had settled on C1 and was happy there. She had no thoughts of harming herself, and those present agreed that she should come off ACCT procedures. She would remain on C1 for observation, and engage with healthcare staff on that basis.

51. Ms Reed had an ACCT post-closure review on 11 November. She said that she was feeling vulnerable and unwell due to the reduction in her medication. She did not have any thoughts of harming herself.

#### **14 December to 11 January**

52. On 14 December, Ms Reed attended court. As the psychiatric report the court had ordered on 14 October to assess her fitness to plead had not yet been completed, she was remanded to reappear on 18 December for an update on the status of the report and to consider setting a trial date.
53. On 18 December, Ms Reed attended court and the court noted that the psychiatric report had still not been prepared. The case was relisted for mention on 4 January, without Ms Reed's attendance being required.
54. On 20 December, Ms Reed attended a review of her IEP status. She had received two recent negative entries, so was returned to the basic level for seven days.
55. On 22 December, an officer heard Ms Reed shouting at another prisoner, although he was unable to hear what was said. He spoke to the other prisoner, who said that Ms Reed was not well and should not be on D3 wing. He spoke to Ms Reed, but she shouted back at him. He gave her an IEP warning. Ms Reed's mother was due to visit her that day but her visit was cancelled. It is not clear why.
56. That afternoon, the community psychiatrist from the South London and Maudsley Trust went to Holloway to assess Ms Reed's fitness to plead so he could provide the required report to the court. Ms Reed did not seem to want to engage with him. Officers on the wing reported that, after seeing him, Ms Reed had been upset and claimed that other prisoners were talking about her. She threatened to kill both them and prison officers.
57. Ms Reed had written to her mother telling her that she was not receiving her medication. Ms Reed's mother told the investigator that she tried several times to speak to someone in Holloway but her telephone calls were unanswered. She therefore contacted a local voluntary organisation and the same afternoon the mental health nurse had a phone call from one of the workers there. He said he was calling on behalf of Ms Reed's mother, and that she was concerned that her daughter's medication had been stopped. She said that she was not able to pass on any information without written consent from Ms Reed to share information with other people. The caller said he would pass on the message to Ms Reed's mother.
58. An intelligence report dated 26 December noted that Ms Reed had been screaming and shouting in her cell for 45 minutes. She had been screaming obscenities and making threats against prison officers. Other prisoners on the wing said that this happened every night and they were tired and frightened for their safety as Ms Reed seemed unstable. The report noted that this was an ongoing issue and that a prison officer referred Ms Reed to the mental health team.

59. On 27 December, an officer visited Ms Reed, and asked her about her threats the previous day. Ms Reed repeated them, and would not engage with him any further. The following day, another prisoner told a prison officer that Ms Reed had been making further threats against staff and prisoners. The prisoner said she was afraid for her safety. Ms Reed was then abusive and aggressive to a prison officer. Her seven day period on the basic IEP level was extended to 28 days. Ms Reed denied threatening staff, but said she understood why this was being extended.
60. On 28 December, an officer was checking prisoners' post. She noted that Ms Reed had written in a letter that she was thinking of cutting her own throat, and that she had dreamed about being attacked by a demon. She noted that Ms Reed's behaviour and mental health had deteriorated over the previous week and therefore began ACCT procedures. It was agreed that Ms Reed would remain on D3 that night and that staff should check her at least three times an hour, recording the checks every four hours. They decided that she would see the mental health team the following day and staff would reassess her location. That night, Ms Reed was shouting and screaming from her cell, upsetting other prisoners on the wing. She refused to engage with a nurse who tried to talk to her.
61. On 29 December, a Supervising Officer (SO) assessed Ms Reed under ACCT procedures. Ms Reed said she had a headache, her eyes were hurting, and she had been unable to sleep. She said that she had harmed herself in the past, but only when drinking and taking drugs, and had not harmed herself since arriving in Holloway. She said that she felt low, had not been eating, and had no-one to talk to. She said she felt like cutting herself and that she was being bullied on the wing, although she did not say who was responsible. The SO noted that Ms Reed should see the doctor about her medication and a possible return to C1.
62. The same day, Ms Reed asked another prisoner to keep watch while she assaulted two others. When the other prisoner refused, Ms Reed said that she would attack them with boiling water instead. Officers noted that her behaviour had been threatening towards staff and prisoners over recent days, and they suspected that she was bullying other prisoners. Ms Reed was moved to the segregation unit.
63. A custodial manager chaired an ACCT review with several staff. Ms Reed engaged well. She said that she had not slept for five days, which had aggravated an eye infection. She felt that being in the segregation unit would help her and she was happy to move from D3. The ACCT caremap recorded that Ms Reed had not been sleeping, and that she should do so in the segregation unit. It noted that she should see the doctor about her medical concerns. Ms Reed said that she was bored. Staff noted that they had given her items to keep her busy.
64. Prisoners regarded as being at risk of suicide and self-harm should be held in segregation units only in exceptional circumstances, but there is no record that anyone considered whether it was appropriate for Ms Reed to be segregated while being managed under ACCT procedures.

65. Ms Reed was due to have a visit from a friend that afternoon, but the friend did not attend. Prison officers on the unit were concerned about Ms Reed's behaviour and contacted the mental health nurse. She told the unit manager that Ms Reed was reacting to the community psychiatrist's visit the previous week. That evening, Ms Reed saw a nurse about the swelling which had developed under her right eye. It was sore and gave her a headache. The nurse gave her some paracetamol and offered her a cold compress, which Ms Reed declined. The nurse noted in her medical record that Ms Reed should see the doctor during the medical round the following day.
66. During the morning of 30 December, Ms Reed was calm but at lunchtime began shouting abuse out of her window. She was due a visit from her partner at 6.00pm but, as she was again standing at her window shouting abuse, the visit was cancelled. Prison staff were not clear whether she was shouting at someone in the prison or was hearing voices. She remained awake, shouting, screaming and swearing through the night. Because of her unpredictable behaviour, officers were told not to unlock her unless three officers were present.
67. On 31 December, a scheduled visit from Ms Reed's partner was also cancelled. Notes on her ACCT record showed that she was aggressive and demanding, appearing angry and occasionally shouting. When the duty governor visited the segregation unit at 2.10pm, Ms Reed was polite but when a prison GP and the mental health nurse visited her at 3.20pm, she was very agitated and extremely angry about a prisoner in the mental health assessment unit. The GP noted that she did not appear to have signs of an enduring mental illness, did not require hospitalisation at that time and recorded that she was fit to remain in the segregation unit. He asked staff to ensure that she was kept apart from the other prisoners. At 4.00pm, staff noted Ms Reed was having an argument with an imaginary woman. Her prison record noted that she was unpredictable and shouting out of her observation panel at a prisoner upstairs on D3. Ms Reed continually pressed her cell bell, demanding a light for a cigarette, but would not interact with staff.
68. On the morning of 1 January 2016, Ms Reed was abusive and threatening. An operational manager agreed Ms Reed's continued segregation status but, because of her high risk behaviour, Ms Reed was not present. Under "mental health concerns", the authority for continued segregation form noted that she was very unpredictable but recorded no specific concerns about her harming herself at that time.
69. Later that morning, the operational manager chaired an ACCT review with Ms Reed present, along with several staff. Because of her unpredictable behaviour the review was held in Ms Reed's cell. She appeared calmer and said that she had no intention of harming herself. The ACCT form showed that her risk was judged as low but that the level of observation should remain the same. The caremap was updated to record that Ms Reed required a period of assessment on C1, and should move there when a place became available. It was also noted that Ms Reed would benefit from family contact, and that she would need to maintain her calm behaviour to ensure she could receive a visit from her mother the following day.

70. Throughout the afternoon of 1 January, Ms Reed continued to behave erratically, shouting out of her window. She was due to have a visit from her partner, but due to concerns over her behaviour this was cancelled. A member of the IMB spoke to Ms Reed that afternoon and noted that she claimed to have been bullied when on D3 wing. She seemed unsettled and looked unwell. A nurse saw her that evening, and noted on her medical record that she was conscious and responsive but appeared tired and “spaced out”.
71. Ms Reed did not sleep well during the night, and was shouting and pressing her cell bell. She was heard laughing out loud to herself, and during the morning rang her cell bell five times in succession asking the same question: could she have her methadone? Staff were still not allowed to unlock her without three officers being present.
72. On the afternoon of 2 January, Ms Reed’s mother visited her. Because of Ms Reed’s unpredictable behaviour the visit was held in a communal room in the segregation unit, rather than in the visits hall. The extra arrangements meant that the visit was shorter than usual. Ms Reed’s mother said that she was concerned at her daughter’s appearance. The dark rings under her eyes were so pronounced that she initially thought they were bruising. Ms Reed seemed distracted and did not appear to want to talk much. Although they were alone in the room, prison officers were watching through the glass door. Ms Reed’s mother felt that one officer in particular seemed hostile. She said that the officer who escorted her out of the prison afterwards said that prison officers did not think that Ms Reed should be in prison, but in hospital.
73. When the duty governor spoke to Ms Reed at 4.00pm she appeared dazed and behaved bizarrely. Throughout the rest of the evening she was mostly calm but would occasionally scream at random. She refused all her meals, but banged on her door and demanded a light for a cigarette numerous times.
74. Throughout 3 January, Ms Reed continued to behave erratically and sometimes aggressively. She refused breakfast but repeatedly requested a light for a cigarette. A note in her segregation history sheet said that she was clearly unwell. When the duty governor saw her at 2.50pm, Ms Reed did not raise any concerns but her behaviour continued to be erratic during the afternoon, and she appeared to have arguments with imaginary people in her cell.
75. On 4 January, Ms Reed’s behaviour continued to be unpredictable. She shouted from her cell, repeatedly asked for a light, and was talking to herself. At 2.30pm, one of the prison’s operational managers chaired an ACCT review with several staff. Ms Reed was drowsy and distracted, and did not participate a great deal. The prison psychiatrist asked about her medication, but Ms Reed kept repeating details of what she had taken in the past. The doctor asked her about going to C1 for a period of assessment, and Ms Reed seemed confused. She said that she would like to go to C1 but a prisoner she had previously had a fight with was resident there so she was unsure. She said she felt unwell, and had experienced pain in her chest for some time. The psychiatrist said she would follow this up, and review her medication. Although she said that Ms Reed was fit to remain in the segregation unit, the doctor asked that she go to C1 wing for a period of assessment as soon as a space became available. The review assessed Ms

Reed's risk of suicide and self-harm as low. Staff would continue to check her at least twice per hour.

76. Ms Reed continued to behave erratically, banging, asking for a light even after one had been given, shouting abuse and cursing other prisoners. This continued throughout the night and Ms Reed rang her cell bell repeatedly. The next morning she refused to take her methadone.
77. On 5 January, Ms Reed was moved to C1. Because of the change in circumstances, the healthcare wing manager held an ACCT review with several staff. Ms Reed appeared tense. She was aware that she would remain on a three officer unlock and was on the basic IEP level, although staff did allow her to have a television which was not usually allowed for prisoners on the basic IEP level. Staff still had concerns about the threat that Ms Reed presented to the prisoner she had fought with, and decided that she would have her meals in her cell until Friday 8 January. Ms Reed's risk of suicide and self-harm was judged as remaining low. The review agreed to reduce the level of staff checks to a minimum of once an hour with a view to considering ending ACCT management procedures at the next review. Ms Reed had a visit scheduled for 5 January but it was cancelled.
78. On 6 January at 1.00am, Ms Reed pressed her cell bell and asked for a light. She did so again 20 minutes later, and records show that at 1.40am she was shouting. After this she slept until woken by noise from another prisoner at 5.00am. At 11.00am, she said she wanted to see a doctor, although she did not specify why. She was very unsettled through lunchtime, banging her door and screaming obscenities, and continued to be agitated and loud throughout the afternoon. At Ms Reed's request, prison officers removed the television from her cell. Ms Reed had not bathed or cleaned her cell, and wing officers decided that her behaviour made it unsafe to offer her exercise.
79. Throughout the night of 6-7 January, Ms Reed continued to be unsettled, misusing her cell bell to ask for a light. When the night staff handed over to the day shift, she was aggressive to the extent that prison officers did not feel it was safe to give her a light for a cigarette or any hot water. At 11.00am, she asked the wing officers to take all her property and throw it away. The officers took her property and put it in storage. The wing observation book described Ms Reed's behaviour as manic throughout the day and she continually pressed her cell bell. That afternoon, an independent psychiatrist from the South London and Maudsley Trust went to see her for a scheduled visit. Ms Reed refused to engage, tried to attack him and had to be locked in her cell. She refused her dinner and was screaming and banging in her cell, shouting on religious themes.
80. Ms Reed continued to shout religious phrases, bang her door, ring her cell bell, pace her cell and talk loudly to herself. When prison officers asked her to keep the noise down she was abusive. The next morning, 7 January, she was screaming, shouting and rolling on her bed, but when offered medication was abusive and tried to punch a prison officer through the hatch in her door. That afternoon she pressed her cell bell, and when officers answered she was violent and aggressive, spitting through the hatch at them and threatening them. The wing manager said that because of her threats and behaviour, staff should not

unlock her unless there were three officers and the wing manager present. She continued with religious chanting. A note entered on her ACCT document at 1.00pm said that she appeared to be psychotic and very unwell. This behaviour continued through the afternoon, causing disturbance on the wing. Ms Reed refused her dinner and, in the evening, continuously rang her cell bell and banged on her door. She tried to attack a prison officer through her hatch and spat at people who came near. She continued to shout religious chants throughout the night.

81. In light of her visit on 2 January, and her daughter's appearance and demeanour, Ms Reed's mother had been very concerned. She said that she recognised the indications that Ms Reed was in crisis. When she had previously tried to contact the prison to express concerns she had not been able to speak to anyone, so on 7 January she contacted the NHS Customer Care service. They said they would try to contact Holloway and let Ms Reed's mother know when they had done so.
82. On 8 January, a note entered in the wing observation book by a SO recorded that Ms Reed's mental health appeared to be deteriorating and she was becoming increasingly aggressive towards staff. She had talked about using a knife to assault prison officers.
83. Staff held an ACCT review at 10.55am. The summary recorded that Ms Reed was unable to attend as she was psychotic and aggressive. She was shouting about God and the devil, and rolling on her bed and screaming. She did not, however, appear to present a heightened risk of self harm, and officers would continue to check on her at least once per hour. A doctor was to review her medication. In the afternoon, Ms Reed continuously rang her cell bell and banged on her door, and her abusive behaviour began to escalate. She was spitting at people through her hatch, throwing things at it, and threatening staff. A note on her record said that her mental health appeared to be deteriorating. She was due to see her solicitor that afternoon but because of her unpredictable behaviour, when the solicitor arrived, she was told that the visit could not take place.
84. That afternoon, the NHS customer care team telephoned Ms Reed's mother. They said that they had tried several times to contact the prison but had been unable to speak to anyone in the healthcare department. They said that they would try again after the weekend.
85. Ms Reed was awake into the night, talking to herself, crying, banging, shouting, and screaming. In the times when she was quiet, she lay on her bed but did not sleep. Staffing levels are lower at night, and because Ms Reed was now on a three officer, plus manager, unlock, staff had not been able to give her lights for cigarettes, or hot water. Nurses provided her medication at 10.00am on Saturday 9 January, and her file shows that, although she continued to behave in a bizarre manner, she appeared to be tired and fighting against sleep. She was noted to be calmer than the previous day, but appeared to be distracted, ignoring prison officers when they spoke to her. In the afternoon, she banged her cell door and shouted that she wanted to see the IMB. When prison officers checked on her she was standing in her cell staring at the wall. She said that her sister was in one of the other cells but was going to be murdered and someone should

call the police, and argued with an imaginary person in her cell. She accepted dinner and her medication in the evening, but then continued intermittently banging and shouting.

86. Ms Reed remained awake through the night, alternately banging, shouting religious phrases, pressing her cell bell, screaming, pacing her cell and talking to herself. On the morning of 10 January, she refused her medication and the offer of a cigarette but accepted breakfast. She seemed confused and disorientated, and officers cleaned her dirty cell. Over the course of the morning, she became agitated and began to ring her cell bell with various demands. She was reaching out of her door hatch, and shouting abuse at staff and prisoners. When a nurse went to give her some toilet roll through the hatch, Ms Reed ran at the hatch and tried to grab her, shouting abuse and threats. She was chanting religious phrases, and referring to herself in the third person. She appeared to be talking to hallucinations in her cell. In the evening, she accepted dinner, a cigarette and her medication, but refused her methadone. Her ACCT document notes that she was very aggressive. At 8.10pm she was asleep, but at 10.30pm was banging loudly on her door demanding a light for a cigarette.
87. A nurse was on night duty on C1 that night. She told the police that she and colleagues conducted ACCT checks on Ms Reed at least hourly during the night. When checked, Ms Reed was sometimes found to be chanting, sometimes sitting or lying on her bed, sometimes standing up. At 10.30pm, she banged on her door asking for a light, which was given. She was awake but mostly quiet until 4.15am when she began shouting and banging her door. At approximately 7.00am on 11 January, she banged on her door and asked her for a light. She gave her a light and spoke to her, but Ms Reed did not answer. She said in her statement that at no point did she think that Ms Reed presented a risk to herself.
88. On the morning of 11 January, Officer A came on duty and, at 7.00am, conducted an ACCT check on Ms Reed. He noted on the ACCT document that she was standing in her cell. An SO came on duty at 7.30am and said that during the handover period Ms Reed was banging on her door. The duty governor asked whether Ms Reed was being transferred to hospital, and a nurse told him that as far as she was aware the local mental health team had been asked to come to Holloway and assess her for transfer. An officer said that, at approximately 7.50am, she could hear Ms Reed banging in her cell.
89. Because Ms Reed was, by now, on a three officer, plus manager, unlock and had tried to assault a nurse the previous day, the staff on duty discussed how they could safely provide her with medication and breakfast. They decided to do so at 8.00am, before unlocking the other prisoners. Two nurses prepared her medication and an officer collected her breakfast. Several staff then went to Ms Reed's door.
90. A screen had been positioned in front of the door to stop Ms Reed spitting at people passing by, so they moved the screen, and Officer A knocked on the door. He opened the observation panel, and saw that Ms Reed was lying on the bed with something tied round her neck. He unlocked the door, telling his colleagues what he had seen, and the officers went in. A nurse ran to the office to collect the emergency response bag, and alerted a colleague.

91. Officer B saw that Ms Reed had a strip torn from a bed sheet wrapped loosely around her neck. He pulled it away. The SO said that when he saw the loose piece of cloth he was not certain whether it was an urgent situation and told the officers not to call an emergency code. However, Officer B then saw that there was another strip of cloth beneath the first, wrapped tightly around Ms Reed's neck. Officer A saw this and shouted to the SO that he should call an emergency code. At 8.04am, the SO radioed to the control room that there was a code blue emergency, indicating that a prisoner was unconscious or having difficulty breathing. In response to the emergency code, the control room requested an ambulance. Officer B called Ms Reed by name, and placed her fingers under the ligature to allow Officer A to use his anti-ligature knife to cut it.
92. Ms Reed was limp and unresponsive. The officers rolled Ms Reed into the recovery position, and Officer C felt that her face was cold. He checked for a pulse but could not find one, and nor could Officer A. At this point a nurse arrived with the emergency bag, and asked them to help him move Ms Reed to the floor. He checked for breathing and a pulse but could detect neither. Other staff had also arrived in response to the emergency call. A manager began to perform cardiopulmonary resuscitation (CPR) and a nurse managed Ms Reed's airway. The manager asked the nurse to confirm that an ambulance was on the way, which she did, then returned to the cell with a defibrillator (a life-saving device that gives the heart an electric shock in some cases of cardiac arrest). The defibrillator found no shockable heart rhythm and advised that CPR should continue. The SO and prison medical staff continued to try to revive Ms Reed until ambulance staff arrived at 8.17am and took over. Paramedics tried to revive Ms Reed, but at 8.56am they pronounced her dead.

### Contact with Ms Reed's family

93. At 9.12am, the prison governor telephoned Ms Reed's mother and informed her that her daughter had died. Ms Reed's mother asked her to call her back in an hour. At 9.50am, the governor telephoned Ms Reed's partner and informed him that Ms Reed had died.
94. When the prison governor telephoned Ms Reed's mother a second time, she informed her that the prison's family liaison officer would visit her that afternoon. She said that she herself would call again at 12.00pm to confirm the details. When she telephoned Ms Reed's mother at 12.00pm, Ms Reed's mother said that she and other family members would attend Holloway. She asked if they would be able to view her daughter's body. The governor said that she would seek guidance from the Coroner.
95. At 1.00pm, Ms Reed's mother, brother, great-aunt, and grandmother arrived at Holloway. The prison governor, the appointed family liaison officer and the prison's Head of Residence & Services met them. Ms Reed's mother asked if they could view her daughter's body. The prison governor took her, together with Ms Reed's brother, to speak to the police officer investigating Ms Reed's death and the City of London Police Director of Forensic Services. They explained that Ms Reed's cell remained a crime scene and, as such, it was not appropriate to allow anyone access. Ms Reed's mother said that they wanted to view her

daughter's body prior to the post-mortem. The Director of Forensic Services arranged this for the following morning before the post-mortem began.

96. In line with Prison Service policy, the prison offered a contribution to the costs of Ms Reed's funeral.

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

97. After Ms Reed's death, the prison governor debriefed the staff involved in the emergency response to ensure they had an opportunity to discuss any issues arising, and to offer support. No note was taken. The staff care team also offered support.
98. Prison officers informed each unit individually of Ms Reed's death and told prisoners where they could access support. The prison also posted notices informing other prisoners of Ms Reed's death, and offering support. Staff reviewed all prisoners subject to ACCT management procedures in case they had been adversely affected by Ms Reed's death. Additionally, a number of prisoners were put onto ACCT monitoring that day.

### **Post-mortem report**

99. The post-mortem found that Ms Reed had died as a result of compression of her neck. The report shows that the pathologist found no facial injuries beyond those consistent with attempts at resuscitation. The report indicated no damage to Ms Reed's teeth, and said that there were no typical defence wounds from assault and no injuries to suggest that Ms Reed had suffered a significant assault by any third party shortly prior to her death.

# Findings

## Ms Reed's healthcare

100. The clinical reviewers noted that Ms Reed had an extensive healthcare history, with a number of psychiatric diagnoses as well as psychotic symptoms that had no diagnosis. The review also noted that her condition and engagement fluctuated, and her behaviour made it difficult for healthcare staff to complete clinical assessments.

## *Ms Reed's medication*

101. The clinical reviewers noted that the prison was unable to ascertain why Ms Reed was on all her prescribed drugs. The decision to stop her quetiapine prescription was supported by assessments and evidence and as such was a reasonable decision. The decision did not, however, take into consideration the anxiety that coming off the medication caused to Ms Reed. In normal circumstances, we would make a recommendation with regard to this, but as Holloway has since closed, we simply draw attention to the issue.
102. On 30 December, the community psychiatrist offered his opinion that Ms Reed should receive anti-psychotic medication. At a complex case review on 31 December, the prison healthcare team decided not to prescribe at that stage however and, on 7 January, decided that, although Ms Reed might benefit from anti-psychotic medication, this should not be taken while in prison but in hospital. Ongoing uncertainty about Ms Reed's diagnosis made it difficult to know what medication she needed, and her previous cardiac problems and refusal to co-operate when staff tried to treat her, made it difficult to monitor the benefits and dangers of any drugs prescribed. The clinical reviewers were satisfied that the issue received proper consideration.

## *Consideration of transferring Ms Reed to hospital*

103. Guidance on transferring prisoners to hospital is contained in Prison Service Instruction (PSI) 50/2007 (*Transfer of Prisoners To and From Hospital Under Sections 47 and 48 of the Mental Health Act 1983*) and NHS England's 'Good Practice Guide – The transfer and remission of adult prisoners under s47 and s48 of the Mental Health Act'. NHS guidance recommends that all prisoners are transferred to hospital within 14 days of the first doctor's assessment that finds the prisoner meets the criteria for transfer.
104. When the community psychiatrist saw Ms Reed on 22 December, he did not consider a transfer to hospital was necessary. When he and the prison psychiatrist discussed Ms Reed's care on 29 December, they also concluded that she did not need hospitalisation at that time. On 30 December, the community psychiatrist told the prison psychiatrist that he still did not consider that Ms Reed needed hospitalisation. On 31 December, a complex case review did not recommend transfer to hospital. Ms Reed was assessed by healthcare staff each day to ensure that she was fit to remain in the segregation unit. She was judged sufficiently fit to stay there until 4 January. At that stage, the deterioration in Ms Reed's mental health was cause enough for the prison psychiatrist to ask for her to transfer to the mental health wing for assessment. This happened the

following day. On 7 January, at a complex case review held only two days after she had moved to the mental health wing, it was agreed that Ms Reed should be referred for a transfer to hospital. A prison GP drafted the letter of referral the next day but, as this was a Friday, the prison psychiatrist did not see the letter to sign it off until 11 January, by which time Ms Reed had died.

105. It is the clinical reviewers' opinion that this timescale was not unreasonable, and that prison healthcare staff properly considered the need for a transfer to hospital.

#### *Ms Reed's potassium levels*

106. Ms Reed suffered from bulimia nervosa. This can cause sufferers to have low potassium levels. Her mother told the investigator that in the past Ms Reed had been given potassium intravenously when her levels were particularly low. The clinical reviewers noted that the only evidence in Ms Reed's GP notes of her potassium levels being monitored was when she attended the accident and emergency ward of a hospital in the community. Other than that, there was no evidence that she had had her potassium levels monitored regularly in the community and there was therefore no reason for healthcare staff in the prison to do so. The clinical reviewers commented that when Ms Reed did report symptoms that might have been linked to low potassium these were investigated. The clinical reviewers also noted, however, that the prison's management of Ms Reed's bulimia was erratic. Weight, diet and vomiting charts were either not undertaken or not consistently maintained. As Holloway has now closed we make no recommendation about this.

#### **ACCT**

107. Having been identified as being at risk of self-harm, ACCT procedures were appropriately opened for Ms Reed when she arrived at Holloway on 14 October. She remained under ACCT procedures until 5 November. Staff began ACCT procedures again on 28 December and these were still in place when she died.
108. We have previously made a recommendation to Holloway about continuity of case management of ACCTs, and HM Inspectorate of Prisons also commented on the issue in its last annual report on Holloway. During her time in Holloway, Ms Reed moved between residential units, which could have made it difficult to ensure continuity in her ACCT management. From 28 December onwards, each ACCT review was chaired by a different manager. The reviews were broadly multidisciplinary, however, and, apart from one occasion, there was always someone at the review who had attended the previous one, which provided some degree of continuity.
109. Ms Reed was moved to the segregation unit on 29 December, the day after she was put on ACCT management procedures. There is no record that the staff considered the need for any additional support to mitigate the risks of holding Ms Reed in the segregation unit,
110. We have previously recommended to Holloway that prison staff making observations on prisoners under the ACCT system should record these as soon as possible after they were made. It was practice at Holloway not to record ACCT observations individually but to make summaries. Notes on Ms Reed's

ACCT documents reflect this. We have no reason to believe that staff did not conduct the necessary checks on Ms Reed, but without commensurate notes in the ACCT document we are unable to verify this. Prison Service Instruction (PSI) 64/2011 sets out the policy on ACCT management and states that observations should be recorded immediately or as soon as is practicable. We consider that, in line with this, all observations should be recorded as they are made.

111. Ms Reed had told health staff on her arrival at Holloway that she had cut her throat eight weeks earlier. She went on to express suicidal feelings on 22 and 29 October and, on 3 November, she told a doctor that she felt suicidal all the time. Despite this, an ACCT review held on 5 November agreed that she should come off ACCT management procedures. On 12 December, Ms Reed wrote a letter stating an intention to cut her throat. Notes of the ACCT case review held on 1 January 2016 showed that Ms Reed's behaviour remained volatile and unpredictable. Despite this, and her recorded history of suicidal thoughts, her risk was assessed to be low.
112. On 5 January, when Ms Reed moved to C1, staff at her new location held an extra ACCT review in view of her change in circumstances. This was good practice, but the review did not include any medical staff (although the manager of the healthcare wing was present). Furthermore, those at the review decided to reduce the minimum level of observation to once per hour, with the possibility of ending ACCT procedures at the next review. Ms Reed had been displaying increasingly disturbed behaviour, had just moved to the mental health wing, and was being assessed for a move to hospital. The decision to reduce vigilance at this time seems counter-intuitive. We have previously made a recommendation to Holloway about setting the appropriate level of observation under the ACCT process.
113. ACCT caremaps should reflect the prisoner's needs, level of risk and the triggers of her distress. Instructions state that the caremaps should aim to address issues identified in the ACCT assessment interview and later reviews, and consider a range of factors including health interventions, peer support, family contact and access to diversionary activities. Each action on the caremap should be tailored to the individual needs of the prisoner, be aimed at reducing risk and be time-bound. We do not consider there were appropriate caremap actions aimed at reducing Ms Reed's risk.
114. In June 2015, we issued a Learning Lessons Bulletin about self-inflicted deaths in segregation units. One of the learning points was that, all too often, prisoners at risk of suicide and self-harm were housed in the segregation unit without sufficient evidence that staff had considered other options or identified exceptional circumstances. PSO 1700, *Segregation, special accommodation and body belts*, highlights that there is a disproportionately high number of self-inflicted deaths in segregation units, and prisoners under ACCT management should be held there only in exceptional circumstances. The reasons must be clearly documented in the ACCT record and include options that were considered and discounted. PSI 64/2011 reinforces this and says that prisoners on open ACCT plans must be located or retained in segregation units only in exceptional circumstances and the reasons must be clearly documented in the ACCT record and include other options that were considered.

115. Despite the closure of Holloway, the breadth of our concerns about weaknesses in ACCT procedures makes it necessary to make a recommendation to the National Offender Management Service (NOMS):

**NOMS should ensure that prisons manage prisoners subject to ACCT procedures in line with national policy, including:**

- **Mental health staff attend or contribute to all ACCT reviews for prisoners with mental health issues, and are fully involved in decisions about their level of risk;**
- **Setting levels of observations which are appropriately adjusted as the perceived risk changes;**
- **Recording ACCT observations immediately or as soon as possible after they are made; and**
- **Effective caremap objectives are set that are specific and meaningful, aimed at reducing risk and updated at each case review**
- **Prisoners assessed as at risk of suicide or self-harm are not held in the segregation unit unless all other options have been considered and excluded, and there are fully documented reasons to explain the exceptional circumstances.**

#### **Family contact**

116. PSI 64/2011 states that prisoners on ACCT must be encouraged to communicate with their families, and that consideration must be given to inviting the prisoner's family to case reviews. We accept that this will not always be easy but Ms Reed's family was supportive and wanted to be involved. On 1 January, when the ACCT caremap was updated, it was noted that family contact would be a helpful factor. Ms Reed's mother's contact details were noted on the document and case managers could have invited her to participate in a review by telephone or in writing. However, Ms Reed's ACCT plan contains no evidence that any case managers considered inviting her family to case reviews, or otherwise took practical steps to involve them in the process. Again, this has broad implications and we therefore make the following recommendation:

**NOMS should ensure that ACCT case managers are aware that they should give proper consideration to involving the prisoner's family in the ACCT process and record this in the ACCT plan.**

117. PSI 64/2011 instructs that all staff receiving information indicating a change in the risk that prisoners pose - including from concerned family members - must communicate those concerns immediately to a manager. They must also make an appropriate record. Ms Reed's mother told the investigator that she tried several times to speak to someone in Holloway to convey her concerns but had been unable to make contact with anyone via the switchboard. When a local volunteer organisation contacted the prison on her behalf, still, nobody from the prison followed up with her. She subsequently contacted the NHS customer care line, and provided us with a log provided by them detailing seven telephone calls made to Holloway on the afternoon of Friday 8 January. The NHS representative was unable to reach a member of the healthcare team on any of these occasions. Ms Reed was under ACCT management, and it is important that staff are made

aware when a prisoner's family raise concerns about a prisoner who has been judged to present a risk to themselves. There is general learning here and therefore make the following recommendation:

**NOMS should ensure that prisoners' families wanting to express concerns about the wellbeing of a prisoner are able to do so.**

## Visits

118. On several occasions Holloway cancelled Ms Reed's visits. Ms Reed's mother told the investigator that more than once she had arrived at the prison only to be told that she was not listed as a visitor. Visits from friends and family were also cancelled on 19 November, 22, 30 and 31 December 2015, and 1 and 5 January 2016. Additionally, on 8 January, Ms Reed's solicitor arrived at the prison but was prevented from seeing her.
119. PSI 16/2011 contains the policy on visits. The PSI notes that Prison Rules 34 and 73(1) give governors discretion to refuse social visits. The rules do not, however, apply to visits by legal advisers. The instruction also states that the decision to allow any visit must be balanced against the need to maintain security and keep prisoners in lawful custody. Prison Service Order (PSO) 4600 contains guidance on unconvicted prisoners (Ms Reed was being held on remand) and notes that while they can receive as many visits as they wish, within reasonable limits, this can be tempered by considerations of security, operational need and practical considerations. When making such restrictions, however, the prison must be able to justify them.
120. Ms Reed's behaviour had been particularly difficult on 8 January, when she had been abusive to prison officers, threatening to assault them, throwing things at her door, and spitting at people passing her cell. When her legal adviser arrived at the prison, she was told that the visit could not go ahead. We appreciate the difficulties that might have arisen from trying to supervise a visit in these circumstances, but this does not appear to jeopardise security or relate to keeping Ms Reed in lawful custody. There is no documentation to say why the visit was cancelled, or whether staff considered a closed visit. Denying a remand prisoner access to legal advice is a significant decision. In this instance, the repeated decisions to cancel visits, denying Ms Reed the opportunity to see members of her family and legal adviser, left Ms Reed relatively isolated. When Ms Reed was in the segregation unit and unable to go to the visits hall during her mother's visit on 2 January, staff made special arrangements so that the visit could go ahead in the unit. This was a good example of the prison being flexible in challenging circumstances, and it is a pity that similar flexibility was not shown on other occasions.

## Incentive and earned privilege scheme

121. In view of her challenging behaviour, Ms Reed was frequently on the basic level of the IEP scheme. Although prison officers did, despite this, allow her a television when she moved to C1 in early January, Ms Reed had a reduced level of freedom within Holloway because of her IEP level. We accept that prison officers do have to manage challenging behaviour, but this behaviour can also be a symptom of a prisoner in crisis and might require a proper behaviour

management plan. Decisions to place prisoners on the basic regime must be made with a view to this. In Ms Reed's case this should have been with the additional consideration of her known mental health issues. Holloway's violence reduction policy stated that, when dealing with poor behaviour by prisoners with mental health issues, the mental health team should be consulted, and this documented. There are no indications on Ms Reed's electronic record or medical file that the mental health team were consulted when Ms Reed was put onto the basic IEP regime. There is a broad lesson to be learned here and we make the following recommendation:

**NOMS should ensure that prisoners who are frequently penalised under the incentives and earned privileges scheme are assessed for a behaviour management plan.**

## Bullying

122. Ms Reed's family said that they feared that Ms Reed was being bullied. While she was sometimes involved in, mostly verbal, altercations with other prisoners, intelligence reports or speculation also suggested that on more than one occasion she herself was suspected of bullying other prisoners.
123. When Ms Reed was on D3 in December, she said she thought other women were talking about her but it is not clear how much of this was delusion due to her deteriorating mental state. Prisoners said that they did witness other prisoners verbally abusing Ms Reed, although her forthright behaviour did invite disagreement. After Ms Reed died, a calendar was found among her papers in which she had written that she had been threatened by other prisoners, and named one. She said that she asked a prison officer if she could move, but her request was ignored. She wrote that she was scared for her safety. The notes are entered onto the calendar at 28 December, though we are unable to know whether Ms Reed wrote them on that date. Ms Reed had been shouting at the prisoner she named some days previously and, on 28 December, this prisoner told a prison officer that Ms Reed had been making threats against staff and prisoners, and that she was afraid for her own safety. There is no further intelligence about any issues between Ms Reed and this other prisoner, including any notes from any staff member, indicating that Ms Reed had asked to be moved. We are therefore unable to comment further.
124. Ms Reed informed prison officers on two occasions, and a member of the IMB once, that she was being, or had been, bullied. She repeated this at her ACCT assessment interview on 29 December, although she would not say by whom. There is no reference to this in the immediate action plan, nor in the ACCT care map, although she had transferred to a different unit by the time the caremap was completed. Holloway's violence reduction policy stated that where bullying is suspected, perpetrators should be challenged and victims asked for their account of what happened. There are no indications that anyone asked Ms Reed who was bullying her.
125. Ms Reed's mother said that she was concerned that her daughter was having problems with some prison officers and mentioned an officer by name. The officer worked on H1 and C1 units and was working on C1 when Ms Reed arrived there on 5 January, and for some of 9 January. Although she would have

had some interaction with Ms Reed in this time, the prison said that it would have been minimal. There were no complaints from Ms Reed about the officer. The investigator repeatedly asked to interview the officer, but she did not respond to specific requests for interview.

126. One prisoner whom the investigator interviewed mentioned problems between Ms Reed and an officer on D3, who made only one entry on Ms Reed's prison record. Holloway said that they had no record of any problems between Ms Reed and the officer, and Ms Reed had submitted no complaints about her. The investigator asked to speak to the officer, but was unable to arrange an appropriate appointment to interview her.
127. Ms Reed's mother also said that a supervising officer she spoke to when she visited her daughter on 2 January seemed hostile towards her and Ms Reed. The investigator spoke to the SO, the wing manager who spoke to Ms Reed's mother that day. The SO said that he was not aware of any problems between Ms Reed and any officers on the segregation unit, and he personally had no difficulties with her. There was no intelligence reflecting any problems between Ms Reed and this officer, and she had submitted no complaints about him.
128. We have not been able to find that Ms Reed was being bullied. There is little evidence to suggest so, but Ms Reed did complain of it and the prison ought to have implemented its violence reduction policy appropriately. She did not complain of being bullied after she moved to C1 on 5 January, and there were no reports that she was being bullied there. None of the prisoners on C1 said in interview that they had witnessed anything. In normal circumstances we would make a recommendation with regard to this, but as Holloway has since closed, and as it is not possible to show that bullying was a factor contributing to Ms Reed's death, we simply draw attention to the issue.

### Contact with Ms Reed's family when she died

129. The prison governor telephoned Ms Reed's mother and informed her over the telephone that Ms Reed had died. The family liaison officer log noted that this was to ensure that she was made aware of the situation as soon as possible. Prison Rule 22 does require prisons to inform the next of kin immediately if a prisoner dies or is taken seriously ill. However, PSI 64/2011 states that, wherever possible, a family liaison officer and another member of prison staff must visit a prisoner's family in person to break the news of a death. Ms Reed's family lived in London and for prison staff to travel to their home would not have led to an undue delay. This is an issue with general application and we make the following recommendation:

**NOMS should ensure that, where possible, a member of staff informs a prisoner's family in person of their death, in line with national instructions.**

130. Ms Reed's family asked to view her body in her cell. The prison governor took advice from the Coroner's staff and from the City of London police. The investigator spoke to the City of London Police's Director of Forensic services and to the police officer who attended the prison. Both confirmed that they told the prison governor that Ms Reed's family would not be able to view her body in her cell. Both also said that they thought that Ms Reed's mother appeared to

accept that she would not be able to do so within the prison but could do so the following morning, although Ms Reed's mother denied that she accepted this. The cell was a crime scene and the prison governor had been told by the police that she could not let Ms Reed's family view her body in situ. In the circumstances, she was obliged to abide by their instructions.

131. Ms Reed's mother told the investigator that, in the initial phone call from the prison governor, she was told that Ms Reed had hanged herself. When the prison governor spoke to her on the telephone subsequently, she told her that Ms Reed had been found with a torn bed sheet around her neck. Then, when she and her family arrived at the prison, they were told that two pieces of torn sheet had been around her neck. When the investigator spoke to the prison governor, she said that as far as she recalled she was fairly sure that she did not say that Ms Reed had been hanging. Nevertheless, providing incorrect information can be distressing for bereaved families, and it is important that prison staff liaising with bereaved families provide the correct information. Again this issue has general application and we therefore make the following recommendation:

**NOMS should ensure that staff breaking news to bereaved families provide as accurate information as possible.**

**Prisons &  
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