

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Ms Jenny Swift a prisoner at HMP Doncaster on 30 December 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.

On 30 December, prison staff discovered Ms Jenny Swift hanged in her cell. Nursing staff attended and attempted to resuscitate her, but paramedics pronounced Ms Swift dead. She was 49 years old. I offer my condolences to Ms Swift's family and friends.

Ms Swift was preoperative transgender and had been living as a woman since 2009. Prior to her remand into custody, she had been purchasing hormone replacement therapy (HRT) tablets via the internet. As these had not been prescribed through an official source, medical staff at Doncaster did not prescribe her with this medication.

Reviews were held to discuss whether Ms Swift was suitable to be transferred to the female estate. This process was managed well, in line with HM Prison and Probation Service policy. Ms Swift was subject to self-harm and suicide prevention monitoring while at Doncaster. These procedures were managed appropriately. Despite Ms Swift being subject to monitoring, there was little to indicate that she was at an increased risk of suicide in the days immediately before her death. We do not consider that prison staff or healthcare staff could have anticipated or prevented Ms Swift's death.

However, despite Ms Swift's good overall care at Doncaster, the clinical review has concluded that the healthcare Ms Swift received, which related to her transgender status, was not adequate to meet her needs and therefore not equivalent to that which she would have received in the wider community.

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**

**August 2017**

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# Summary

## Events

1. On 17 November 2016, Ms Jenny Swift was remanded into custody at HMP Doncaster, charged with attempted murder. On her arrival, Ms Swift was said to have been volatile and threatening toward staff. She was initially located in the segregation unit. During an initial healthcare screen, Ms Swift identified herself as transgender and, although documentation referred to her by her legal given name, she told staff that she preferred to be addressed as 'Jenny'.
2. Ms Swift said that prior to custody she had been taking Hormone Replacement Therapy (HRT), purchased from the internet, on a regular basis. Healthcare staff decided not to prescribe HRT treatment while in custody as it had not been officially prescribed by a GP. Referrals were made at the initial healthscreen for Ms Swift to be seen by a member of the mental health team and a GP. Ms Swift was assessed by the mental health team, but she said that she did not require their input, and was discharged from their caseload.
3. Ms Swift told staff on a number of occasions that not having access to HRT medication was having a detrimental effect on her physically and mentally. Further referrals were made to the GP but, despite these, Ms Swift was never seen or assessed by a GP while at Doncaster.
4. With the help of probation staff from the local courts, the Doncaster safer custody team arranged Ms Swift's care and sought the most suitable location for her to be assessed in line with Prison Service Instruction (PSI) 17/2016, *The Care and Management of Transgender Offenders*. In all, three case reviews were held during November and December, and the team concluded on 15 December that there was enough information and evidence to support a recommendation for Ms Swift to be transferred to the female prison estate.
5. Due to her behaviour when she first arrived at Doncaster and information received at reception, Ms Swift was placed on suicide and self-harm monitoring procedures (known as ACCT.) Ms Swift remained on ACCT throughout her time at Doncaster. On 6 December, staff found her slumped on the floor of her cell with a ligature around her neck. Staff entered the cell, removed the ligature and nursing staff and an emergency ambulance were requested. However, as soon as staff had removed the ligature Ms Swift became abusive and confrontational, refusing any treatment. Staff therefore increased Ms Swift's observations to five per hour for the remainder of that night. At an ACCT case review the following day, Ms Swift denied any intent to self-harm again or to take her own life. She was said to be happy, laughing and joking and the observations were returned to twice an hour.
6. On the evening of 29 December, a PCO and a Custodial Operations Manager (COM) were on duty. The PCO had been checking Ms Swift as part of the ACCT observation every half hour during the evening, and last checked her at around 12.30am. He said that she was awake and, when asked, told him that she was fine. At approximately 12.37am, just after he had returned to the wing office, a cell call light was pressed on the cell next door to Ms Swift. Both the PCO and

the COM went on to the wing to answer the call and were asked by a prisoner if they could ask Ms Swift to turn her music down.

7. The PCO looked into Ms Swift's cell through the observation panel and saw her suspended from her bed with a ligature around her neck. They entered the cell, cut the ligature from around Ms Swift's neck and radioed for medical assistance and an ambulance. The COM began cardiopulmonary resuscitation (CPR) and continued until the arrival of nursing staff, who then took over. Treatment continued until the arrival of paramedics at 12.42am. Paramedics continued to treat Ms Swift, but at 1.10am she was pronounced dead.

## Findings

### Management of Transgender Policy

8. At the time of Ms Swift's remand HMPPS had just introduced a new Prison Service Instruction (*PSI 17/2016, The Care and Management of Transgender Offenders*). The investigation has found that all actions taken to support Ms Swift and assess her suitability for the female estate were timely and in line with the revised PSI.
9. Overall, we consider that Doncaster's management of Ms Swift's transgender status was appropriate and reasonable and that the prison did all that could be expected in line with the instruction. However, we do have concerns regarding Doncaster's clinical care of Ms Swift, which relate to her gender status and these are set out below.

### Assessment, care in custody and teamwork (ACCT)

10. A full ACCT assessment and a first case review were completed and attended by mental health staff, with subsequent reviews being completed as required. All of these were multidisciplinary. ACCT observations were set at appropriate levels and staff completed these accordingly. Following Ms Swift's attempted hanging on 6 December she refused treatment, but observations were appropriately increased. However, nursing staff failed to record the event in the medical record. This meant that those nursing staff accessing the record after this date had no knowledge of the earlier attempt at self-harm.

### Clinical care

11. Ms Swift had been taking hormone replacement therapy medication, which she had bought from the internet prior to her remand into custody. As this was sourced without prescription, it was not prescribed at Doncaster. Despite numerous references being made in the records to GP appointments being scheduled for Ms Swift, she was never seen or assessed by a GP at Doncaster. This was despite her saying on numerous occasions that not having access to her medication was having an adverse effect on both her physical and mental well-being. The clinical reviewer concludes, and we agree, that failure to address this meant the care Ms Swift received while in HMP Doncaster was not sufficient in addressing her needs.

## Recommendations

- The Director and Head of Healthcare at HMP Doncaster should ensure that all staff participate in education and training in respect of the needs of transgender persons and, in particular, they should be familiar with their responsibilities in respect of the HMPPS instruction on transgender prisoners.
- The Head of Healthcare should ensure that in all instances where a prisoner self-harms and healthcare staff attend, it should be noted within the SystemOne healthcare record in order to inform members of the healthcare team in their subsequent work with that prisoner.
- Given the likely complexity of their needs, the Head of Healthcare should ensure that all transgender persons admitted to Doncaster benefit from a comprehensive healthcare assessment in respect of their physical and mental health and are seen by a GP and a member of the mental health team as soon after admission as practical.

## The Investigation Process

12. The investigator issued notices to staff and prisoners at HMP Doncaster informing them of the investigation and asking anyone with relevant information to contact him. Two responses were received and these prisoners were interviewed as part of the investigation.
13. HMP Doncaster provided copies of relevant extracts from Ms Swift's prison and medical records.
14. A clinical reviewer was appointed to review Ms Swift's clinical care at the prison.
15. The investigator and clinical reviewer interviewed 19 members of staff and two prisoners at Doncaster.
16. We informed HM Coroner for Doncaster of the investigation. The Coroner provided the post-mortem results, which give the cause of death as hanging. Toxicology indicated that no illicit substances were present in Ms Swift's system.
17. One of our family liaison officers contacted Ms Swift's mother on 2 February 2017 to explain the investigation. Ms Swift's mother said that the prison's management had been quite good and that she had no outstanding questions or concerns. She said that she had last spoken with Ms Swift on Christmas Day and she had not picked up anything that indicated her daughter's intentions. Ms Swift's mother said that, in her opinion, her mental health had been deteriorating since she began taking the HRT medication.

# Background Information

## HMP Doncaster

18. HMP Doncaster is a local prison, operated by Serco, which holds up to 1,145 remanded and sentenced men and young male offenders. At the time of Ms Swift's death, Nottingham Healthcare NHS Foundation Trust was providing physical and mental health services, and substance misuse services

## HM Inspectorate of Prisons

19. The most recent inspection of HMP Doncaster was conducted in October 2015. The Inspectorate found that prisoners were negative about their experience of healthcare and there was evidence of deterioration in provision, mainly owing to staff shortages.

## Independent Monitoring Board

20. Each prison in England and Wales has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community, who help ensure that prisoners are treated fairly and decently. In its most recently published annual report for the year to September 2015, the IMB noted that a shortage of nursing staff meant doctors were taking on nursing duties, which had caused delays with appointments to see a doctor.

## Previous deaths at HMP Doncaster

21. Ms Swift was the second self-inflicted death of a prisoner at Doncaster in 2016. There were no similarities with Ms Swift's death and findings from earlier investigations.

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

22. Assessment, Care in Custody and Teamwork (ACCT) is the Prison Service care-planning system 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 risk and how best to monitor and supervise the prisoner. 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)*.
23. 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 multidisciplinary review meetings involving the prisoner. As part of the process, a caremap (a plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions on the caremap have been completed.

## Transgender Prisoners

24. Her Majesty's Prison and Probation Service (HMPPS) introduced a new instruction in November 2016, PSI 17/2016, *The Care and Management of Transgender Offenders*. The mandatory actions relating to transgender offenders within the instruction came into force on 1 January 2017. The instruction requires there to be a Local Transgender Case Review Board convened to:
  - Determine the individual's location within the correct part of the prison estate, based on strength of evidence of living in the gender the offender identifies with and all known risk factors;
  - Form a local agreement for an initial care and management plan;
  - Draw up a voluntary agreement where such an agreement is agreed;
25. There is no defined time frame for assessments to be completed, although it is expected that the process for assessing a prisoner and submitting a recommendation would be expedited in as short a time frame as possible.

## Key Events

26. Ms Jenny Swift was remanded into custody on 17 November 2016, charged with attempted murder. While at court, Ms Swift told custody staff that she expected to be in prison for 15 years, would have nothing to come out to, and would slit her neck and kill everyone. Staff also recorded that Ms Swift needed medication (although this referred to a drug that had not been prescribed) and she was displaying 'bizarre' behaviour. Staff recorded all the information on a Suicide and Self-Harm (SASH) warning form, which accompanied Ms Swift to Doncaster.
27. When Ms Swift arrived in the reception area at Doncaster, she was recorded as being very volatile and confrontational. A mental health nurse was on duty in reception and attempted to assess Ms Swift on arrival. She recorded that this was difficult as Ms Swift was quite aggressive, agitated and volatile. However, she was able to record that Ms Swift had previously been a psychiatric inpatient, but she refused to discuss her previous mental health history any further. She recorded that when asked, Ms Swift denied thoughts of deliberate self-harm or having any suicidal thoughts.
28. Given Ms Swift's behaviour, an officer was present throughout the reception screening. The nurse recorded that Ms Swift was taking "spiatotone", (the clinical reviewer has indicated that this was likely to have been spironolactone, a medicine that can lower the testosterone levels in the body). Ms Swift also said that she had been taking hormone replacement therapy, but was not in receipt of any prescribed medication at that time.
29. As the SASH form had been received from court and Ms Swift continued to display unpredictable and volatile behaviour at reception, staff opened an Assessment, Care in Custody and Teamwork (ACCT) document in reception and began monitoring Ms Swift.
30. The Assistant Director for Safer Custody at Doncaster was the duty director on 17 November. She said that Ms Swift had presented as calm one minute then really angry and aggressive. She authorised that Ms Swift be initially located in the segregation unit overnight, as she did not feel it would have been appropriate to locate her on the induction wing with other prisoners at that time. She completed documentation detailing her reasons for segregating Ms Swift. Ms Swift was observed by staff at least five times an hour. No further issues or concerns were recorded.
31. On 18 November, a Prison Custody Officer (PCO) completed an ACCT assessment interview with Ms Swift. She recorded that Ms Swift denied any thoughts of self-harm and said that her only issue was that she had not had any HRT medication since the previous Friday. Ms Swift denied having previously self-harmed, and said that she had no concerns about being in prison. She also said that she suffered from anxiety, but did not wish to be prescribed medication for this.
32. Following the assessment, Ms Swift attended the ACCT case review, also attended by a mental health nurse and a member of the safer custody team. During the case review, Ms Swift was recorded as open, and spoke about previous periods of custody. She again denied any thoughts of self-harm or

suicide. She told the staff that she preferred to be called 'Jenny', and would appreciate the support of the mental health team. The case review recorded that based on her presentation and the evidence available, Ms Swift's risk of further self-harm was low, and she could be relocated to the vulnerable prisoner wing on houseblock 1 and that staff should complete hourly ACCT observations. A mental health nurse had attended the review and recorded on the medical record that Ms Swift had been briefly sectioned under the Mental Health Act in October, following a psychotic episode.

33. On 21 November, a mental health nurse visited Ms Swift in her cell. He recorded that Ms Swift told him that she was transgender, wanted to be left alone, and had not had HRT medication for ten days. Ms Swift told him that she suffered from anxiety. During the conversation with him, Ms Swift spoke about her fluctuating mood, her desire to smash her cell, feeling depressed and wanting to cry all the time, which she said were all due to her hormones being "all over the place". Ms Swift told him that she had been taking HRT for 18 months and suddenly stopping was a shock to her system. When asked about thoughts of self-harm, Ms Swift reportedly said that if she intended to self-harm, she would not tell anyone.
34. The nurse recorded in the medical record that he was seeing Ms Swift as part of an ACCT review. However, there was no review on 21 November, and the comments made by Ms Swift were not recorded by him in the ACCT document or mentioned to any other member of staff. He said that in his opinion the problems with medication raised by Ms Swift were not a mental health issue, so he had contacted a member of the primary care team to follow up on this. He explained that the mental health team would see any prisoner placed on an ACCT, and this was what he was referring to on the record.
35. On 22 November, a pharmacy technician was approached at the medication hatch by Ms Swift, who requested HRT medication. She told her that prior to custody she had purchased her medication via the internet. The technician told her that as it was not prescribed by a GP she would not be able to provide her with this medication. She recorded that Ms Swift then became very aggressive towards her and said she would "smash the place up" if she did not get her medication. She said that due to Ms Swift's presentation, she referred her to the mental health team.
36. A second ACCT case review was held on 24 November, chaired by a Custodial Operations Manager (COM). Ms Swift was described as being in high spirits, and waiting for more work to be done with the mental health team. No staff from the mental health team attended this review. Ms Swift was assessed as still posing a low risk of self-harm, but the review team recommended that the ACCT document remain open.
37. The mental health nurse saw Ms Swift again on 28 November and completed a mental health assessment with her. Ms Swift denied any thoughts of self-harm but said she felt nervous, anxious and on edge nearly every day. Ms Swift also admitted to not being able to stop or control worrying, having trouble relaxing, difficulties sleeping and feeling bad about herself nearly every day. Despite this, Ms Swift said that she did not need or want input from the mental health team

and just wanted her medication. Ms Swift told him that she felt that her testosterone levels were rising and she was “all over the place” and was annoyed about this. He recorded that primary care nursing staff were addressing medication issues, although there is no evidence that this was the case. At a mental health multi-disciplinary meeting later that day, a nurse recorded that Ms Swift was functioning well and had declined input from the MH team. As a result, Ms Swift was discharged from their caseload.

38. A PCO who is the Foreign National and Equalities co-ordinator at Doncaster, told the investigator that probation staff at Doncaster court had notified him on 16 November that a transgender prisoner would possibly be arriving into custody on 17 November. He said that, on 17 November, he received an email from the Assistant Director asking him to engage with Ms Swift at his earliest opportunity. However, he said that due to annual leave, he was not able to speak with Ms Swift until 24 November. He said that he arranged a meeting with Ms Swift and she had support from other transgender prisoners at that time. Initially, he spoke with Ms Swift and around four other transgender prisoners in his office and then spoke with Ms Swift separately. He said that she gave him a detailed account of what she was hoping would happen while in custody and also spoke about her past.
39. The PCO said that Ms Swift identified the fact that she had been self-medicating prior to custody and told him that since stopping her medication she had become very angry and was experiencing mood swings.
40. As a remand prisoner, Ms Swift had not had any pre-sentence contact with probation staff at court. However, Doncaster had recently successfully overseen the transfer of another transgender prisoner to the female prison estate, with the help of staff from the National Probation Service, and Doncaster asked them to assist with Ms Swift’s case, which probation staff agreed to do.
41. The first Transgender Case Review Board meeting took place on 29 November, chaired by a Senior Probation Officer at Doncaster Courts. Also in attendance were the Equalities and Foreign National coordinator HMP Doncaster; a Probation Officer, Doncaster Court Team; a MOJ Controller HMP & YOI Doncaster; Equalities Team HMPPS; Assistant Director safer custody and the Senior Equality Manager HMPPS. There was no healthcare representative at the meeting although one had been invited.
42. The panel confirmed that Ms Swift was legally male but that if there was strong evidence that Ms Swift’s gender identity was female, then a recommendation for her to move to the female estate could be made. The Equalities and Foreign National co-ordinator told the review that Ms Swift had stated that she wanted to be located in the female estate, and had said that if she was not moved there, she would take her own life.
43. The Equalities and Foreign National co-ordinator told the panel that Ms Swift told him that prior to custody she was taking two types of hormonal medication. He believed these were non-prescription but this would require further clarification. He said that Ms Swift was concerned that her body was changing and she was losing her female physical characteristics as she did not have access to the hormones.

44. He had sought input via healthcare from the Leeds Gender Identity Clinic – an NHS service offering assessment and support to people with gender dysphoria – where Ms Swift had previously registered. The information was required to ascertain whether Ms Swift was still engaging with the clinic, whether another referral would need to be made and to identify any further information that might be useful to the panel.
45. The panel noted that one of Ms Swift’s triggers for violence was feeling under attack by discriminatory comments. She was currently on the vulnerable prisoner wing, in a single cell, and had single showers. Staff supervised and escorted her when going to other parts of the prison or attending education. Other prisoners on the unit identified themselves as transgender, and Ms Swift interacted well with them. She had breasts, wore female clothing and did attract a lot of vocal harassment, which was dealt with by wing staff. Ms Swift had access to make up and other female products. A risk management plan was sought for the end of November.
46. On 6 December, at around 8.00pm, following an ACCT check, a PCO found Ms Swift sitting on the floor of her cell with a ligature around her neck attached to the bed frame. She immediately used her radio to inform the control room of a code blue emergency (which indicates that a prisoner is either unconscious or has breathing difficulties).
47. The PCO said that when she entered the cell, Ms Swift was not moving, but was conscious. She cut the ligature from around Ms Swift’s neck and laid her on the floor. Ms Swift began swearing and shouting and became quite volatile. Nursing staff responded to the code blue, but Ms Swift refused to speak to them. There were no obvious injuries and the ambulance was stood down. Nursing staff did not record they had responded to a code blue in the medical record or make any entry on the ACCT document. Ms Swift refused to speak with staff and her ACCT observations were increased to five per hour for the remainder of the night because of her actions.
48. At 10.30am on 7 December, an ACCT review was completed. Ms Swift said that she felt that she was withdrawing from her HRT medication and, as a result, had not been sleeping. She spoke about her wish to transfer to the female estate and told the review that there was a further meeting regarding this the following Tuesday. A Custodial Operations Manager (COM) chaired the review and said Ms Swift wanted to be transferred to a female prison. The Equalities and Foreign National co-ordinator attended the review, which recorded that he would look into the issues about medication. The COM said that other than these issues, Ms Swift indicated that she was happy on the wing, was mixing well, had friends and voiced no thoughts of, or further intent to, self-harm. The reviewers considered that Ms Swift posed a low risk of further self-harm at that time, and they agreed her observations would be reduced from five per hour to two per hour.
49. On 12 December, the MOJ Controller visited Ms Swift on the wing. Ms Swift was more settled than she had expected. Ms Swift spoke about the effects of not taking the HRT, including not being able to sleep, but told her that she was due to see the GP on 18 December. She said she had been told that this was the earliest appointment available.

50. The MOJ Controller discovered that the appointment with the GP was scheduled for 14 December. She went to her cell to tell her but Ms Swift became quite volatile, indicating that she should not be on a sex offenders' wing. She also voiced her dissatisfaction that another transgender prisoner had recently successfully moved to HMP New Hall, a female prison, before she had, which she felt was unfair. She said it was impossible to engage with Ms Swift, so she left the cell.
51. On 13 December, the second Transgender Case Review took place, attended by those in attendance at the first review, with the addition of both Ms Swift and the Clinical Matron. Ms Swift explained to the review that she had lived five out of the last eight years as a female and continuously for the last three years. She said that she had breasts and was "a girl", and should not be in a male environment. Ms Swift said that she felt discriminated against and was finding the experience traumatic. The review team attempted to explain the process to Ms Swift, but she became agitated and was returned to the wing. The meeting continued and a nurse stated that it was obvious Ms Swift was frustrated and had again made threats to self-harm. The Clinical Matron said that Ms Swift had refused to engage with the mental health assessment process, and had declined all interventions, and no attempts to complete further assessments had been made.
52. The Equalities and Foreign National co-ordinator said that he had attended the most recent ACCT review with Ms Swift and she had been unable to identify what the trigger was for her self-harm. However, the Senior Equality Manager said that Ms Swift's most recent probation report indicated that the main trigger for her was feeling discriminated against. A nurse reiterated the need for a further mental health assessment and the decision was taken to increase her ACCT observations to four per hour. The Assistant Director indicated that Ms Swift was due to appear in court within the next few days, which raised her anxiety. The review team spoke all agreed that she should be transferred to the female estate, but further information was required from the Gender Identity Clinic before the completed application could be submitted to the Deputy Director of Custody (DDC) for approval.
53. The PCO who attended the Transgender Review attended an ACCT review the following day, 14 December, with Ms Swift. She said that Ms Swift presented as completely the opposite to the previous day; she was in good spirits, laughing, joking and apologised for her earlier behaviour. Ms Swift told the review that she was aware that people were trying to help her. She also said that she was due to appear in court via video link the following day for a plea hearing, and this was causing her some worries. The PCO said that she provided Ms Swift with some activity books to occupy her while in her cell and told her that staff had arranged a further Transgender Review for the following day to discuss her case further. Based on her presentation and positive interaction the ACCT review agreed to reduce Ms Swift's observations back to two per hour.
54. The third and final Transgender Review took place on 15 December, attended by those who had been present at earlier reviews. There was no representative from healthcare present. The previously agreed position was restated, noting that information remained outstanding from the Gender Identity Clinic. The team

agreed that there was no need for further reviews and they were now in a position to submit the application. The Assistant Director and MOJ Controller would collate the dossier of evidence to be submitted to the Deputy Director of Custody for the female estate, who would make the final decision.

55. The Assistant Director said that although the dossier was not submitted to the Deputy Director of Custody prior to Christmas, Ms Swift was made aware that its recommendation was for her to move to the female estate. She said that even if the dossier had been submitted at that point, it was unlikely that any decision would have been made prior to the New Year.
56. During the meeting, the team were informed that Ms Swift had been remanded into custody until 24 April 2017 and would appear at Crown Court. Ms Swift had pleaded not guilty to attempted murder during her court appearance and her trial would begin on 16 May 2017. A PCO was asked to keep Ms Swift updated on the outcome of the meeting.
57. On reviewing the medical record, the investigator discovered a letter addressed to Ms Swift and copied to her community GP from the Gender Clinic in Leeds. The letter, dated 15 November 2017, had been faxed to the prison along with other information by the GP on 13 December after being requested by the Clinical Matron following the transgender review. The letter indicated that the Gender Clinic had been apprised of Ms Swift's current situation by the police. The clinic had decided that in her current situation, Ms Swift was not in a sufficiently stable position to go any further with the gender reassignment process. The clinic informed Ms Swift and her GP that the decision had been taken to remove her from their caseload, but if circumstances changed, she could be referred again in the future. Despite the information being available, it was never shared by the healthcare team with the transgender review panel. The investigator told a nurse about the letter. The nurse said that, although surprised that the information had not been shared, it would not have changed the recommendation of the panel that Ms Swift should move to the female estate.
58. On 17 December, Ms Swift was informed that the victim of her alleged offence had died and staff asked a nurse to speak to her. A nurse went to speak to Ms Swift in her cell and addressed her as 'Jonathan', as recorded on the medical notes. Ms Swift became angry and told him that her name was 'Jenny'. He recorded that Ms Swift was difficult to engage with and became verbally and racially abusive. At this stage he said that he terminated contact with Ms Swift, and told staff to contact healthcare if Ms Swift calmed down and wished to see a nurse. A referral was also made to the mental health team.
59. On the evening of 18 December, at approximately 8.00pm, it was reported that Ms Swift had cut her thumb and the Clinical Matron went to see her on the wing. He recorded that when he arrived at Ms Swift's cell, she stated that she did not wish to be seen by a black nurse, refused any treatment and was verbally and racially abusive. Staff spoke with Ms Swift later that evening and it was recorded in the ACCT that her issues remained her medication and her concerns regarding her court case. Her observations remained at two per hour.
60. On 19 December, a mental health nurse went to see Ms Swift in order to complete a mental health assessment. She recorded that there was dried blood

on the wall from an apparent cut on Ms Swift's thumb. She recorded that Ms Swift was aware that she could now be charged with murder, but indicated that her main concern remained not receiving her HRT medication. She recorded that Ms Swift stated that she blamed the prison for this and that they had failed in their duty of care towards her. She tried to explain to Ms Swift that the medication could not be provided, as it had not been prescribed via proper channels.

61. Following her assessment with Ms Swift, the nurse also attended an ACCT review with her, chaired by a PCSO and attended by two PCOs. It was again recorded that Ms Swift was frustrated about her medication, but was in better spirits than she had been over the weekend. Ms Swift said that despite her volatile behaviour she would not hurt staff and asked for medication to help her sleep. Ms Swift was told that her transfer to HMP New Hall was a possibility, but no date had been set. The nurse said that she would speak with the GP about sleeping medication. The review discussed the possibility of reducing observations to hourly, but due to recent changes in circumstances, it was decided that they should remain at two per hour.
62. Despite staff referring to GP appointments made for Ms Swift in the medical record, no GP ever assessed her. On 21 December, a prison GP recorded that he had received a request from a nurse requesting sleeping medication for Ms Swift. He said that due to other problems within the prison on that day, clinics had to be curtailed and he was unable to see Ms Swift. He did, however, prescribe three days of sleeping medication.
63. The nurse visited Ms Swift again on 23 December. She recorded that Ms Swift was much calmer and settled and more willing to engage. Ms Swift talked about her background and the abuse she had suffered since a child. Ms Swift also told her about the effects that her childhood experiences and of being in the army had had on her. Ms Swift again spoke about the lack of female hormones and the effect this was having on her. She said that she had tried the zopiclone (sleeping tablets) but this was not working, and she was awake again within two hours.
64. The nurse recorded that Ms Swift was adamant that she did not need to be located in the Loft Wing (a small wing) and was fully aware that she could receive a 10-15 year sentence for murder. She recorded that they spoke about Ms Swift's son and how she missed him, but as he was only four years old she would still be able to have a relationship with him when released. She had clear plans for the future. She recorded that Ms Swift stated that she had no intent to harm herself or others. She concluded that there was no evidence of psychosis, and she agreed to visit Ms Swift again after the Christmas break.
65. On 28 December, a PCO recorded in the wing observation book that Ms Swift and two other vulnerable prisoners were intending to take their own lives that evening. She said that she had made the entry in the observation book and told the manager on duty.
66. A friend of Ms Swift was one of those prisoners. He also identified himself as transgender. The investigator spoke with him, who confirmed that he and a number of other prisoners had agreed to what he referred to as a "suicide pact". However, he was adamant that Ms Swift was not party to this. He said that he

and other vulnerable prisoners felt that they were being treated unfairly by certain staff and had taken the decision to take their own lives in protest. He said that while Ms Swift was angry about her treatment and lack of medication, she had not been part of the suicide pact.

67. On 29 December, Ms Swift attended a Transgender Forum meeting chaired by the Equalities and Foreign National co-ordinator, along with two other transgender prisoners. He said that Ms Swift spoke openly and engaged well with everybody at the meeting, as she had at other meetings. He said that Ms Swift raised a few concerns, but could not recall what these were specifically. He said that Ms Swift was quite happy and did not appear down in any way. He said that after the meeting, Ms Swift sat with him in his office and they spoke. He said that Ms Swift asked him if a friend could bring some earrings and further clothing in for her. He told Ms Swift this would not be a problem. He said that she was looking forward to engaging with the transgender clinic again. He said when speaking with Ms Swift in his office he noticed nothing untoward in her presentation and she never expressed any concerns to him. He said that the meeting concluded at around 4.00pm. After speaking with Ms Swift, he escorted the prisoners back to the wing, where they returned to their respective cells. He had no further contact with Ms Swift after this.
68. A prisoner told the investigator that at around 5.30pm, he, Ms Swift and another transgender prisoner were unlocked by staff and allowed to use the shower. He explained that this was a normal routine to ensure that as transgender prisoners they had some privacy. He said that staff allowed 20 minutes but they spent around 30 minutes in the shower. Ms Swift was laughing and joking, and gave no indication that anything was wrong.
69. On the evening of 29 December, a PCO was on night duty and covering the patrol on Houseblock 1. A large number of ACCT documents were open at the time, and to ensure that staff could effectively complete observations, a Custodial Operations Manager (COM) said that he was on Houseblock 1 that evening for additional support.
70. The prisoner said that he spoke with Ms Swift during the evening as she was in the cell next door. She spoke about her hormone treatment and gave no indication of being upset. The PCO completed checks every thirty minutes on Ms Swift and the prisoner, who was also subject to monitoring. The investigator was able to confirm that the checks were made by viewing CCTV footage.
71. The PCO said that it was not unusual for Ms Swift to be playing music and dancing in her cell during the night. He said that she did not seem to sleep for a whole night, but would sleep for an hour and then be awake again. He said that he checked on Ms Swift at around midnight and she seemed to be pacing up and down and appeared agitated. When he asked whether she was alright, Ms Swift replied that she was fine. He then checked her again thirty minutes later, and she was still awake. She again told him that she was fine when he asked.
72. The prisoner said that he had spoken to Ms Swift just after the PCO had completed his last check. He told the investigator that he was not sure why, but he felt that something was wrong and he pushed his cell call light to alert staff.

73. The COM said that he had been to patrol the wing and had just returned to the wing office along with the PCO. They both immediately went back to the wing to answer the call bell.
74. The prisoner asked the PCO to ask Ms Swift to turn her music down. The prisoner told the investigator that he asked this as he knew the PCO would have to look in on Ms Swift. When the PCO looked into Ms Swift's cell through the observation panel, he saw her hanging with a ligature around her neck. He broke the seal on his emergency pouch to obtain the cell key and both he and the COM entered the cell. They called a medical emergency code blue using their radios.
75. The COM said that Ms Swift's television was very loud. He unplugged it while the PCO cut the ligature from around Ms Swift's neck. They lowered Ms Swift to the floor and he began administering cardiopulmonary resuscitation (CPR.)
76. While the COM continued CPR, the duty manager attended and took over delivering breaths to Ms Swift. Between them CPR was maintained until healthcare staff arrived.
77. A nurse and a healthcare assistant (HCA) received the emergency call and arrived on the wing at approximately 12.38am. The HCA said that Ms Swift was warm to the touch, but there was an indentation where the ligature had been. The nurses took over resuscitation attempts from officers and Ms Swift was moved onto the landing outside her cell to provide more room for staff to work. First response paramedics arrived at the cell at 12.42am, with other paramedics arriving at 12.45am. Paramedics took over treatment and resuscitation attempts continued until 1.10am, when paramedics pronounced Ms Swift dead.

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

78. An executive support officer was appointed as the prison's family liaison officer. HMP Risley was asked to provide a FLO to inform Ms Swift's mother. HMP Risley appointed a Functional Head, who visited the home of Ms Swift's mother on 30 December and informed her of her daughter's death. The officer then followed up this contact and offered support. The prison contributed to the funeral costs, in line with national policy.

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

79. After Ms Swift's death, an Assistant Director de-briefed the staff involved. Members of the staff care and welfare team were available to those staff that required their support.
80. The prison posted notices informing other prisoners of Ms Swift's death, offering support. Staff reviewed all prisoners considered to be at risk of suicide and self-harm prevention in case they had been adversely affected by Ms Swift's death.

## Post-mortem report

81. The Coroner has confirmed that the initial post-mortem concluded that the cause of death was hanging. Results from toxicology indicate that Ms Swift had not taken any illicit substances prior to her death.

# Findings

## Management of Transgender Policy

82. Ms Swift's death has attracted media attention and differing views based solely on her transgender status. The implementation of the policy and staff actions in relation to this were considered during the investigation. At the time of Ms Swift's remand, HMPPS had just reintroduced a revised version of PSI 17/2016. The investigation has found that all actions taken to support Ms Swift and assess her suitability for the female estate were timely and in line with the revised PSI.
83. The prison did well in expediting the case reviews and collating the required information within a relatively short time frame but it is unfortunate that the dossier was not submitted before the Christmas break. While Ms Swift was made aware of the recommendation in respect of her relocation, and Christmas was approaching, the prison should have known that the onset of the holiday season was likely to cause delay. We cannot know whether submitting the dossier earlier would have made a difference in Ms Swift's case and so make no recommendation.
84. However, healthcare managers and healthcare staff particularly, need to understand the importance of their involvement in this process. There were three reviews held to discuss Ms Swift's care, treatment and most suitable location. Although invited to attend all of these, healthcare staff only contributed to one.
85. The investigation and clinical reviewer also found a lack of understanding of transgender issues amongst staff. A large number of the nursing team and prison staff who were spoken with during the investigation, stated that they had either no or very little knowledge of transgender issues. There were frequent references made in both the prison and medical case notes to Ms Swift being "he" and sometimes "she" and often a mixture of both.
86. Overall, we consider that Doncaster's management of Ms Swift's transgender status was appropriate and reasonable and that the prison did all that could be expected in line with the instruction. However, we do have concerns regarding Doncaster's clinical care of Ms Swift, which relate to her gender status and these are set out below. We make the following recommendation:

**The Director and Head of Healthcare at HMP Doncaster should ensure that all staff participate in education and training in respect of the needs of transgender persons and, in particular, they should be familiar with their responsibilities in respect of the HMPPS instruction on transgender prisoners.**

## Assessment, care in custody and teamwork (ACCT)

87. Guidance on ACCT procedures is set out in PSI 64/2011, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody)*. During her time at Doncaster, Ms Swift was subject to ACCT monitoring.
88. A full ACCT assessment and a first case review were completed and attended by mental health staff, with subsequent reviews being completed as required, all of

which were multidisciplinary. ACCT observations were set at appropriate levels and staff completed these accordingly.

89. On 6 December, staff found Ms Swift slumped in her cell with a ligature around her neck. Healthcare staff attended, but Ms Swift refused treatment. Appropriately, Ms Swift's frequency of observations was increased to five per hour for the remainder of the night. However, the clinical reviewer found that nursing staff made no note of this event in the healthcare record. This meant that those members of healthcare staff who spoke with Ms Swift thereafter were not aware of this instance of self-harm/attempted suicide. The following recommendation is made:

**The Head of Healthcare should ensure that in all instances where a prisoner self-harms and healthcare staff attend, it should be noted within the SystemOne healthcare record in order to inform members of the healthcare team in their subsequent work with that prisoner.**

#### **Clinical care**

90. Ms Swift had been taking hormone replacement therapy medication, which she had bought from the internet prior to her remand into custody. As this had not been prescribed through an official source, it was not prescribed at Doncaster. Despite numerous references being made to GP appointments being scheduled for Ms Swift, she never was seen or assessed by a GP at Doncaster.
91. The clinical reviewer sets out in his report that Ms Swift was a preoperative transgender person who had been committed to a male prison. She identified as 'Jenny', and advised staff that she preferred to be addressed by this name. She also said that she had been taking hormone replacement therapy and later told staff on several occasions that not being able to do so in prison was affecting her adversely. He states that a number of members of the nursing team saw Ms Swift during a period of around six weeks while in custody. He concludes that that failure to account more extensively for Ms Swift's deficit meant that the care she Swift received while in HMP Doncaster was not sufficient in addressing her needs. He makes the following recommendations for healthcare:

**Given the likely complexity of their needs, the Head of Healthcare should ensure that all transgender persons admitted to Doncaster benefit from a comprehensive healthcare assessment in respect of their physical and mental health and are seen by a GP and a member of the mental health team as soon after admission as practical.**

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations