

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Ms Nicola Price a prisoner at HMP Downview on 25 August 2018

A report by the Prisons and Probation Ombudsman

Our Vision

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

Our Values

We are:

Impartial: *we do not take sides*

Respectful: *we are considerate and courteous*

Inclusive: *we value diversity*

Dedicated: *we are determined and focused*

Fair: *we are honest and act with integrity*



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

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

Ms Nicola Price was found hanged in her cell at HMP Downview on 25 August 2018. She was 46 years old. I offer my condolences to her family and friends.

Ms Price often told staff that she intended to take her life when she was released from prison. I am concerned that staff appeared to consider that this meant there was little immediate threat and did not appreciate how additional risk factors or triggers might affect a vulnerable woman with such long-term suicidal ideation.

After Ms Price's death, other prisoners told staff that Ms Price had 'inherited' debts from a friend of hers who had been moved to another wing, and that she was the victim of bullying as a result. I am concerned that, although the friend had told staff she was being bullied before she was moved, staff did not investigate, challenge or manage the alleged perpetrators in line with local policy. If they had done so, they would have been more alert to the possibility that Ms Price was being bullied.

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

Sue McAllister CB
Prisons and Probation Ombudsman

April 2019

Contents

Summary	1
The Investigation Process	3
Background Information	4
Key Events	6
Findings.....	12

Summary

Events

1. On 1 February 2018, Ms Nicola Price was sentenced to three years and seven months in prison. When she arrived at HMP Eastwood Park, Ms Price said that she had harmed herself recently and wanted to take her own life. Prison Staff began suicide and self-harm prevention measures (known as ACCT).
2. In her first weeks in prison, Ms Price spoke of her hopelessness and low mood and that she had frequent thoughts of harming herself. She began to settle into prison and, on 6 April, prison staff stopped ACCT procedures.
3. On 12 April, Ms Price was transferred to HMP Downview. Staff at Eastwood Park again started ACCT procedures before the move as Ms Price was unsettled by the thought of it. On 21 May, staff at Downview stopped ACCT monitoring.
4. During her time at Downview, Ms Price told staff on several occasions that she intended to take her life when she was released from prison. She said that she was upset because her son had told her that he did not want any future contact with her. Healthcare staff referred Ms Price to a counselling service.
5. On 20 August, Ms Price's friend, another prisoner, said that she was in debt to other prisoners on the wing so was moved from their wing. After Ms Price died, several prisoners told staff that her friend's debts had passed onto Ms Price and the prisoners whom her friend had named began to bully Ms Price as a result.
6. On 21 August, Ms Price told a prison counsellor that she intended to take her life when she was released from prison. The counsellor told wing staff who concluded that they would monitor her and not begin ACCT procedures.
7. During the morning of 25 August, one of the prisoners later named as having allegedly bullied Ms Price visited her 11 times in her cell. The prisoner told us that they were friends and spent time playing cards. An officer locked Ms Price in her cell shortly after 12.00pm, and said that there did not appear to be anything unusual. At 1.34pm, another officer looked in Ms Price's cell and found her hanging from a ligature. She radioed for assistance, opened the cell and staff began cardiopulmonary resuscitation. Paramedics arrived and recorded that Ms Price had died.

Findings

8. Ms Price often said that she intended to take her life when she was released from prison. We are concerned that prison staff took this to indicate that there was no immediate threat, and did not consider the potential impact that other risk factors and triggers might have on someone with long-term suicidal ideation. It is always a matter of judgement whether to begin ACCT procedures, but had prison staff done so, it would have given them the opportunity to work holistically to reduce Ms Price's underlying level of risk and identify any additional triggers.
9. We found that prison staff did not follow local violence reduction procedures as they should have done. They failed to investigate or challenge the prisoners

named by Ms Price's friend, or consider what might happen to the debt when Ms Price's friend left the wing. As a result, they did not give themselves the best opportunity to identify and support any other prisoners, such as Ms Price, who might be at risk of violence.

Recommendations

- The Governor should ensure that all staff have a clear understanding of their responsibilities to manage prisoners at risk of suicide and self-harm in line with national guidelines and, in particular, the need to record, share and consider all relevant information about risk, and start ACCT procedures, when indicated.
- The Governor should ensure that all information about bullying and intimidation is fully co-ordinated and investigated in line with local policy, including that those suspected of involvement are appropriately challenged and investigated.

The Investigation Process

10. The investigator issued notices to staff and prisoners at HMP Downview informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
11. The investigator visited Downview on 4 September. He obtained copies of relevant extracts from Ms Price's prison and medical records.
12. The investigator interviewed six members of staff and two prisoners at Downview in September and November.
13. NHS England commissioned a clinical reviewer to review Ms Price's clinical care at the prison. The clinical reviewer joined the investigator for the staff interviews.
14. We informed HM Coroner for Surrey of the investigation. The coroner gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
15. The investigator contacted Ms Price's father to explain the investigation and ask if he had any matters he wanted the investigation to consider. Mr Price asked whether his daughter received appropriate care for her mental ill health in prison, and whether prison staff could have done more to keep Ms Price from harming herself.
16. We shared the initial report with HM Prison and Probation Service (HMPPS). Their action plan is annexed to this report. We also shared the initial report with Ms Price's father. He did not make any comments.

Background Information

HMP Downview

17. HMP Downview holds up to 330 sentenced, mostly adult, women. It reopened in May 2016, following a non-operational period of 30 months. Central and North West London NHS Foundation Trust provides healthcare services.

HM Inspectorate of Prisons

18. The most recent inspection of HMP Downview was in August 2017. Inspectors reported that rates of self-harm were low and many women spoke highly of the support they had received from staff in times of crisis. Most women told inspectors that they had a member of staff to turn to if they had a problem, and inspectors found that many staff knew the circumstances of women in their care and the issues affecting them.
19. Inspectors also found that tension and conflict on wings was reasonably well managed. They reported that allegations of bullying were taken seriously and investigated promptly, and ongoing monitoring was rarely necessary.
20. Inspectors found that the mental health team responded promptly to women's needs and provided excellent one-to-one and group support.

Independent Monitoring Board

21. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report for the year to April 2018, the IMB reported that wing staff knew the women in their care well, and took particular note of those they considered to be more vulnerable.

Previous deaths at HMP Downview

22. Ms Price was the third prisoner to die at Downview since the prison reopened in May 2016. Our investigations into the two previous deaths are currently suspended, as we are awaiting action from third parties, and the reports have not yet been issued.

Assessment, Care in Custody and Teamwork

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

around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Care Programme Approach

24. The Care Programme Approach (CPA) is an NHS system of delivering community mental health services to individuals diagnosed with a severe mental illness or other vulnerabilities such as a history of violence or self-harm. Someone who needs CPA support should have a formal written plan that outlines any risks and a CPA care co-ordinator to organise and review the plan.

Key Events

Background

25. Ms Nicola Price had a diagnosis of bipolar affective disorder (a condition marked by alternating periods of elation and depression), and was dependent on cannabis and amphetamines. In 2013, 2015 and 2017, she was admitted to psychiatric units for several weeks at a time for treatment under the Mental Health Act. Ms Price received a monthly depot injection, containing clopixol. (A depot injection slowly releases antipsychotic medication into the body over a number of weeks.) She was also prescribed lamotrigine (a mood stabiliser).

HMP Eastwood Park

26. On 1 February 2018, Ms Price was sentenced to three years and seven months in prison, for arson and owning a dangerous dog. She had been to prison once before, serving a three-week sentence in 2005.
27. A nurse assessed Ms Price in reception at HMP Eastwood Park. She recorded Ms Price's diagnosis, medication and history of psychiatric admission, and referred her to the mental health team. She also recorded that Ms Price had cut herself recently (the specific date is not recorded), was shocked by the length of her sentence and wanted to take her own life. The nurse began ACCT procedures.
28. At an ACCT assessment on 2 February, Ms Price said that she had attempted suicide in October 2017 by "throwing herself onto a sword". At the first ACCT case review that followed, Ms Price said that she had taken several overdoses in the past.
29. Ms Price struggled to settle into prison. In her first weeks in custody, she spoke of a sense of hopelessness and persistent low mood and, on 15 February, she said that she wanted to hang herself. Ms Price also said that she had frequent thoughts of harming herself.
30. On 21 February, a psychiatrist assessed Ms Price. She recorded that Ms Price did not appear psychotic and had no need for admission to a psychiatric hospital at the time.
31. In late February and into March, Ms Price began to settle into prison life. Several members of staff made entries that indicated that her mood had lifted, and the psychiatrist recorded that she was "brighter in mood". At an ACCT case review on 23 March, a Supervising Officer (SO) recorded that Ms Price was now "in a very good place" and the mental health team were happy with the improvement she had shown.
32. On 6 April, the SO recorded that Ms Price was settled on her unit, and was very happy about a recent visit from her grandson and was planning for more visits in future. Ms Price was also happy that a prison job had been identified for her. The SO stopped ACCT procedures.

33. On 11 April, prison staff told Ms Price that she would transfer to HMP Downview the following day. An SO recorded that this news unsettled Ms Price and gave her thoughts of self-harm. She reopened ACCT procedures.

HMP Downview

34. On 12 April, Ms Price transferred to Downview. A nurse assessed her following her arrival, and completed a referral to the mental health team.
35. A mental health social worker was appointed as Ms Price's Care Programme Approach (CPA) keyworker. She assessed Ms Price on 18 April, and took a detailed history. The mental health social worker recorded that Ms Price told her that she found her depot injection helpful in stabilising her mental health. She recorded that Ms Price expressed thoughts of suicide but without any plans about how to do it. Ms Price told her that she had these thoughts because of her transfer and the recent breakdown of her relationship with her son.
36. On 19 April, a psychiatrist assessed Ms Price. He recorded that Ms Price spoke of fleeting thoughts of suicide and self-harm after the breakdown of her relationship with her son. He recorded that he would stop the clopixol depot injection and prescribe aripiprazole (antipsychotic medication used to treat schizophrenia and bipolar disorder), due to side effects Ms Price had experienced. Later in the month, Ms Price began a course of daily aripiprazole tablets rather than a monthly depot injection. He also prescribed an antidepressant medication.
37. At an ACCT case review on 27 April, which was led by an SO, Ms Price said that she had thoughts of suicide due to the lack of contact with her son. The SO recorded that Ms Price had moved to C Wing and settled in well, and that she now worked in the prison kitchens.
38. An officer was appointed as Ms Price's personal officer. She introduced herself on 1 May, and recorded that Ms Price spent a lot of time in her room but had made two friends on the landing.
39. On 9 May, two officers spoke to Ms Price. One of the officers recorded that Ms Price was generally low in mood because her son did not speak to her. Ms Price said that she felt suicidal and "would be dead" if she was not in prison as she would then be able to access medication to overdose.
40. On 11 May, an SO recorded that Ms Price was in good spirits as she now had a place working in the London College of Fashion workshop at Downview. However, she became tearful when speaking about her son and lack of contact with him. Ms Price again said she would be dead if she was outside prison. On the same day, the mental health social worker recorded that she had completed a referral to Choice for Change, a counselling service at Downview, to support Ms Price about the breakdown of her relationship with her son.
41. On 21 May, an SO chaired an ACCT case review which the mental health social worker also attended. The SO recorded that Ms Price's risk of suicide and self-harm was now low, and stopped the ACCT procedures.

42. On 24 May, a psychiatrist reviewed Ms Price's medication. He recorded that he had planned for her to move to a depot injection of aripiprazole, but she preferred to continue taking daily tablets.
43. On 4 June, the mental health social worker reviewed Ms Price. She recorded that her mental health appeared stable, with no evidence of low mood or depression. Ms Price told her that she had resigned from her job at the London College of Fashion as she did not enjoy it, but was attending education. She recorded that there was no current evidence of any risk of self-harm.
44. That afternoon, Ms Price attended her first anxiety group with Choice for Change. The group leader who led the group, recorded that Ms Price said that she had thoughts of ending her life. Ms Price said that she did not think she would act on her thoughts. The group leader recorded that she had discussed this with the mental health social worker and a C Wing officer. The officer recorded that wing staff should "keep an eye on" Ms Price.
45. On 12 June, an officer recorded that Ms Price was now spending more time out of her cell. She noted that Ms Price had applied for work in the prison's photography workshop.
46. The next day, Ms Price did not go the anxiety group and said that she no longer wanted to attend the sessions. Ms Price did not give a reason for this.
47. On 25 June, the mental health social worker recorded that Ms Price said that she did not want to attend her scheduled appointment. She recorded that Ms Price's mental health was stable with no evidence of risk of suicide or self-harm. She noted that she did not think that Ms Price needed further support from the mental health team at the time. The mental health multidisciplinary team discussed this at their meeting on 27 June, and concluded that they should continue to support Ms Price.
48. On the same day, an officer recorded that Ms Price was "fed up and depressed" as she had no job and no friends. She noted that she had tried to encourage Ms Price to chat to other prisoners and come out for exercise, but she liked to keep herself to herself.
49. On 5 July, the officer recorded that Ms Price was now more cheerful and spent more time out of her cell with another prisoner.
50. On 16 July, a substance misuse practitioner reviewed Ms Price's substance misuse care plan. She recorded that Ms Price said that she had no thoughts of using drugs and no thoughts of harming herself. Ms Price said that she had no confidence and spent a lot of time in her cell. She said that she had completed the prison's self-esteem group a week earlier, but did not think that she got much from it. The substance misuse practitioner recorded that she gave Ms Price harm reduction advice and that they agreed to suspend her file for six months.
51. On 24 July, Ms Price asked to see the mental health social worker. She recorded that there was no change to Ms Price's presenting issue, which was that the breakdown of her relationship with her son had resulted in ongoing suicidal thoughts without any plan or intent to act on them. Ms Price reiterated that she did not intend to harm herself in prison. The mental health social worker

recorded that Ms Price did not always take her medication as prescribed and appeared to have very little insight into her issues. She told us that Ms Price sometimes did not take her medication because she found it hard to motivate herself to get out of bed to collect it.

52. On 30 July, a psychiatrist assessed Ms Price. She recorded that Ms Price said that she felt very low and could not get any worse. Ms Price told her that she had received a letter from her son, saying that he did not want to see her again. The psychiatrist recorded that Ms Price had suicidal thoughts but denied that she would act on these. She concluded that Ms Price presented as being depressed, and that they agreed that she would refer Ms Price for counselling about the breakdown of her relationship with her son.
53. On 8 August, an officer recorded that Ms Price kept to herself and had a good friendship with another prisoner. She noted that Ms Price had received an interview letter for a job at the photography studio at Downview and was looking forward to this. The officer told us that Ms Price was offered this job and started shortly before she died. She said that Ms Price seemed excited about the job. Another officer also told us that Ms Price was happy about her new job.
54. On 20 August, Ms Price's prison friend told prison staff that she was in debt to three other prisoners on C Wing, whom she named as Ms A, Ms B and Ms C. She moved to the segregation unit for her own protection. An officer told us that Ms Price was worried when her friend moved from the wing because she did not know why it had happened, and felt lonely afterwards.
55. On 21 August, Ms Price began counselling with a counsellor. She recorded that Ms Price told her that she intended to take her life by overdosing on paracetamol when she was released from prison. Ms Price said that she could not do this in prison because she did not have access to paracetamol. She also told the counsellor that she had no plan to take her life at present.
56. The counsellor recorded that she told wing staff what Ms Price had said, and that they had recommended that she make an entry in the wing observation book (which the counsellor did) and that they would review Ms Price. (It is not recorded who the counsellor spoke to, and she did not know their names.)
57. On 23 August, the mental health social worker assessed Ms Price. She recorded that Ms Price was enjoying her new job, did not have any signs of depression and had been taking her medication as prescribed. Ms Price said that she had no plans to end her life in custody. She concluded that Ms Price's mental health appeared stable. She told us that Ms Price did not say anything about the other prisoner leaving the wing or how she felt about this.

25 August 2018

58. CCTV footage shows that Ms A visited Ms Price's cell 11 times between 8.27am and 11.45am on the morning of 25 August. Sometimes, she only briefly put her head around the cell door, and at other times, she stayed in the cell for several minutes. Ms A told us that they spent time playing cards and talking. She said that Ms Price seemed quite happy.

59. At 10.21am, an officer went to Ms Price's cell. She said that she could not remember the conversation clearly but recalled that they spoke about Ms Price's new job, which she said she enjoyed. The officer said that Ms Price asked about her friend and she told Ms Price that she was not sure what was going to happen to her friend. She said that she did not remember if anyone else was present (Ms A was in the cell at the time) and was not aware of Ms A's frequent visits to Ms Price that morning. She recorded that she would "keep a close eye on [Ms Price] because she has a history of making threats to harm herself". She said that this was a reflection on things she knew Ms Price had said in the past and she did not have any specific concerns about her at the time.
60. At 12.05pm, an officer locked Ms Price in her cell for lunch. Around two minutes later, she checked Ms Price as part of a count of all prisoners. She told us that Ms Price was sitting on her bed and nothing appeared to be unusual.
61. At 1.34pm, an officer went to Ms Price's cell. She looked through the observation panel and saw Ms Price hanging from a ligature made of her dressing gown cord which she had tied to the window. She radioed a medical emergency code blue, and the control room operator telephoned for an ambulance immediately. She then unlocked and went into Ms Price's cell, followed by another officer. Another seven staff arrived within 30 seconds. The officer cut the ligature and found that Ms Price was not breathing and had no pulse. An officer began cardiopulmonary resuscitation. Staff applied a defibrillator, which advised them to continue chest compressions.
62. At 1.39pm, a nurse arrived and took over the resuscitation. Paramedics arrived at 1.50pm. At 2.24pm, they confirmed that Ms Price had died.
63. After Ms Price died, several prisoners told staff that the Ms Price's friend's debts had passed to Ms Price. They said that Ms A and Ms B had bullied and threatened Ms Price on the evening before and morning of her death.

Contact with Ms Price's family

64. A family liaison officer from HMP Eastwood Park visited Ms Price's father on 25 August, and informed him of Ms Price's death. Downview contributed to the costs of the funeral in line with national guidance.

Support for prisoners and staff

65. After Ms Price's death, an operational manager debriefed the staff involved in the emergency response to ensure that they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.
66. The prison posted notices informing other prisoners of Ms Price's death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Ms Price's death. Ms Price's friend in prison told us that she received a lot of support from staff.

Post-mortem report

67. The cause of death had not been identified when we issued our report. After an initial post-mortem examination, the pathologist recorded that the appearance was consistent with hanging.

Findings

Identifying risk of suicide and self-harm

68. Prison Service Instruction (PSI) 64/2011, which governs ACCT suicide and self-harm prevention procedures, requires all staff who have contact with prisoners to be aware of the risk factors and triggers that might increase the risk of suicide and self-harm and take appropriate action. Any prisoner identified as at risk of suicide or self-harm must be managed under ACCT procedures. We have considered whether staff at Downview should have recognised Ms Price as at risk and begun ACCT procedures to support her.
69. Ms Price had some risk factors for suicide and self-harm. She was estranged from her son and it was well-known to staff that this deeply troubled her. Her one recognised friend on C Wing had been moved from the wing, and PSI 64/2011 notes that loneliness can increase risk. Ms Price's friend's debts had allegedly passed to her (although we appreciate that staff did not know this at the time), and bullying, intimidation and the threat of violence are also known risk factors. Significantly, Ms Price often spoke of her intent to end her life when she was released from prison, something she repeated a few days before she died.
70. Staff at Downview recognised that Ms Price had some issues and she received good support from wing and healthcare staff. However, we are concerned that they appeared to treat each issue in isolation and there was no holistic consideration of Ms Price's wider range of risk factors.
71. PSI 64/2011 contains a mandatory instruction that "any member of staff who receives information ... which may indicate a risk of suicide/self-harm must open an ACCT". We are concerned that staff appeared to base their judgements on Ms Price's statement that she would not take her life until *after* she was released from prison, indicating that there was no imminent threat. The regularity with which Ms Price repeated her intent implies that these were not just fleeting thoughts. PSI 64/2011 highlights examples of triggers that might increase risk – and therefore the likelihood of action – in a prisoner who has underlying suicidal thoughts. Although we cannot be certain about the events leading up to Ms Price's death, if her friend's debts were passed to her, it is likely that this would have been a trigger for her actions.
72. In a PPO thematic report into risk factors in self-inflicted deaths, we found that assessments of risk too often place insufficient weight on known risk factors and too much on what the prisoner says and staff perceptions of their behaviour and demeanour. Had staff started ACCT procedures, it would have allowed them to identify and address Ms Price's issues and triggers and work to reduce the impact of any unexpected triggers. While we cannot say that this would have led to a different outcome, it would have given prison staff more chance of preventing her death. We make the following recommendation:

The Governor should ensure that all staff have a clear understanding of their responsibilities to manage prisoners at risk of suicide and self-harm in line with national guidelines and, in particular, the need to record, share and consider all relevant information about risk, and start ACCT procedures when indicated.

Bullying

73. Downview has a local violence reduction strategy which highlights the process of raising and investigating any identified or suspected act of bullying, intimidation or violence. It states that any member of staff who witnesses, suspects or is told of a violent or anti-social act must complete a Violence Reduction Form (VRF) to allow such incidents to be effectively investigated and action taken. It also states that perpetrators must be challenged. The C Wing manager told us that his expectation of the investigation is that staff should interview the alleged perpetrators and pass the VRF with their findings to a supervising officer within 48 hours to recommend appropriate action.
74. Ms Price's friend named three prisoners to whom she was in debt, and she subsequently moved to the segregation unit for her own protection. Two of those prisoners were also named by other women as having allegedly bullied Ms Price in the hours before her death, having passed Ms Price's friend's debts onto her. No one completed a VRF when she raised her issue with staff on 20 August. There is no record of any investigation or that anyone spoke to or challenged the prisoners she named, or considered what might happen to the debt when she left the wing.
75. We cannot be certain about what happened in the days leading to Ms Price's death. However, a PPO publication of June 2011 about self-inflicted deaths in 2007-2009 found that there was evidence of bullying and intimidation in 20 per cent of self-inflicted deaths we investigated. In our PPO thematic report into self-inflicted deaths in 2013-14, we found that reports or suspicions that a prisoner is being threatened or bullied need to be recorded, investigated and robustly responded to. We make the following recommendation:

The Governor should ensure that all information about bullying and intimidation is fully co-ordinated and investigated in line with local policy, including that those suspected of involvement are appropriately challenged and investigated.

Clinical care

76. Ms Price had a significant medical history before prison, including several admissions to psychiatric units. At Downview, she had frequent contact with her keyworker and input from a consultant psychiatrist.
77. The clinical reviewer found that Ms Price received appropriate assessment and follow-up by mental health staff at Downview. He noted that key decisions about Ms Price's care were made at weekly multidisciplinary team meetings. He also found that clinical records were of a consistently high nature and demonstrated a caring and supportive approach to Ms Price's care. He concluded that the clinical care that Ms Price received in prison was equivalent to that which she might have expected to receive in the community.

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