Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Ms Saria Hart, a prisoner at HMP/YOI Foston Hall, on 12 October 2019

A report by the Prisons and Probation Ombudsman

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OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO

WHAT WE VALUE

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.

If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Ms Saria Hart died in hospital on 12 October 2019, after being found hanging in her cell at HMP Foston Hall on 4 October. She was 26 years old. I offer my condolences to Ms Hart's family and friends.

Ms Hart arrived at Foston Hall with a self-harm alert because she had threatened to cut her throat when she was arrested. The investigation found that reception staff failed to consider this information and failed to consider starting ACCT procedures when she first arrived. This was a missed opportunity to put appropriate support in place.

On 3 October, staff restrained Ms Hart after she acted aggressively towards them and refused to return to her room. Staff removed her from her job, placed her on a disciplinary charge and segregated her in her room pending her disciplinary hearing the next day. Later that day, staff started monitoring Ms Hart under suicide and self-harm prevention procedures (known as ACCT) after she wrote a note saying she planned to take her own life.

The next morning, Ms Hart attended her disciplinary hearing and was found guilty. That afternoon, she passed another note to staff saying she could not cope with losing her job, that being confined to her room was damaging her mental health and suggesting that she planned to end her life that night. Just over an hour later, she was found hanging in her room. She was taken to hospital but died eight days later.

There were failings in the management of the ACCT procedures. Staff failed to identify appropriate caremap actions, such as making a mental health referral; the ACCT document was not sent with Ms Hart when she attended her disciplinary hearing; and staff failed to reassess Ms Hart's risk after her disciplinary hearing.

There were also failings in the management of Ms Hart's segregation. No one considered whether Ms Hart's continued segregation was appropriate after staff started ACCT procedures and her fitness for segregation was not reassessed by healthcare staff.

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 **December 2020**

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Summary

Events

1. Ms Saria Hart was remanded in custody on 16 August 2019, charged with burglary and wounding with intent, and sent to HMP Foston Hall. This was not her first time in prison.

2. During her seven weeks at Foston Hall, Ms Hart had several conflicts with other prisoners. She also broke prison rules on several occasions, including being found in an unauthorised area of the prison and smoking an electronic cigarette on the wing.

3. On 3 October, while doing her job as a wing cleaner, Ms Hart flung open the door of the wing office, walked in uninvited and threw a vacuum cleaner down, before walking out. When a custodial manager challenged her, she shouted abuse at him and walked off. She returned to the office, punched and headbutted the window, and shouted at staff. Staff tried to walk Ms Hart back to her room, but she refused to comply. They restrained her but she resisted and kicked out at staff, resulting in staff injuries. She was eventually returned to her room.

4. Ms Hart was removed from her job, placed on two disciplinary charges and segregated within her room pending her disciplinary hearing the next day.

5. Later that day, staff started suicide and self-harm prevention procedures (known as ACCT) after Ms Hart passed a note under her door saying she planned to take her life.

6. On the morning of 4 October, Ms Hart was found guilty on both charges. She was punished with seven days loss of association, 14 days loss of privileges and 50% stoppage of earnings.

7. At around 3.30pm, Ms Hart rang her emergency cell bell. When an officer responded, Ms Hart passed a note to her. It said that she was not prepared to lose her job as that was her only source of income, that remaining in her cell was going to damage her mental health and that she could not do it anymore.

8. An officer let Ms Hart out for a shower at 4.00pm and returned her to her room at 4.15pm. At 4.30pm, a group of prisoners tried to speak to Ms Hart through her cell door, but she refused to speak to them.

9. At 4.45pm, an officer went to Ms Hart's room to carry out an ACCT check and found Ms Hart hanging in her room. She tried to call a medical emergency code over her radio, but the network was busy. She asked a nurse nearby to call the code over her radio and come to help. They cut down Ms Hart. Staff responded and they started cardiopulmonary resuscitation (CPR).

10. Ambulance paramedics continued CPR and managed to get Ms Hart breathing unaided. They took her to hospital, but she never regained consciousness and died on 12 October.

Findings

11. Ms Hart arrived at Foston Hall with a self-harm alert. Her Person Escort Record (PER – a document that accompanies prisoners when they move between police custody, courts and prisons, which sets out the risks they pose), said that she had threatened to cut her throat when arrested. Reception staff failed to consider the information in Ms Hart's PER and failed to consider starting ACCT procedures when Ms Hart arrived at Foston Hall. This was a missed opportunity to put appropriate support in place.

12. There were failings in the management of the ACCT procedures once they were started on 3 October. Staff failed to identify appropriate caremap actions, such as making a mental health referral; they failed to send the ACCT document with Ms Hart when she attended her disciplinary hearing as they should have done; and they failed to reassess her risk after she was found guilty and received her punishments.

13. As Ms Hart's ACCT document did not accompany her to her disciplinary hearing, the Adjudicator did not fully consider her risk factors as he should have done.

14. There were failings in the management of Ms Hart's segregation. When staff started ACCT procedures two hours after Ms Hart was segregated, no one considered whether her continued segregation was appropriate, nor did healthcare staff reassess her fitness for segregation.

15. After Ms Hart was restrained on 3 October, she was seen by a nurse. However, the nurse carried out her examination by looking through the observation panel. This was not acceptable.

Recommendations

- The Operational Manager and Head of Healthcare should ensure that staff conducting reception assessments always examine and consider the Person Escort Record, and any other documents that arrive with the prisoner, to assess whether the prisoner has any risk factors for suicide and self-harm.

- The Operational Manager should ensure that staff manage prisoners at risk of suicide and self-harm in line with PSI 64/2011, in particular staff should:

    - identify caremap actions that are detailed, time-bound and tailored to reduce the prisoner's risk;

    - ensure that the ACCT document accompanies the prisoner when they move around the prison; and review the prisoner's level of risk whenever there is an event or change of circumstances that could impact on risk.

- The Operational Manager should ensure that where disciplinary charges are heard against a prisoner subject to ACCT procedures, the Adjudicator fully considers the prisoner's risk factors on their ACCT plan and records these in the adjudication paperwork. The Operational Manager should ensure that prisoners in segregation are managed in line with PSO 1700, in particular:

    - Prisoners on an ACCT are segregated only in exceptional circumstances.

    - Where a segregated prisoner becomes subject to ACCT procedures, a new healthcare algorithm is completed to check that a prisoner is fit to be segregated and the appropriateness of continued segregation is reviewed promptly.

- The Head of Healthcare should ensure that staff carry out a proper examination of a prisoner after a use of force incident.

The Investigation Process

16. The investigator issued notices to staff and prisoners at Foston Hall informing them of the investigation and asking anyone with relevant information to contact her. Two prisoners responded.

17. The investigator obtained copies of relevant extracts from Ms Hart's prison and medical records. She interviewed 12 members of staff and two prisoners at Foston Hall on 18, 20 and 21 October and 3 and 4 December 2019.

18. NHS England commissioned a clinical reviewer to review Ms Hart's clinical care at the prison. They jointly interviewed staff.

19. We informed HM Coroner for Derbyshire of the investigation. The coroner sent us the results of the post-mortem examination. We have sent the coroner a copy of this report.

20. We contacted Ms Hart's mother to explain the investigation and to ask if she had any matters, she wanted the investigation to consider. Ms Hart's mother raised no issues.

21. An inquest was held on 3 October 2024 and concluded that Ms Hart undertook a deliberate act with the intention of causing her own death by suicide.

Background Information

HMP/YOI Foston Hall

22. HMP Foston Hall is a closed women's prison serving courts in the Midlands. It holds up to 344 prisoners, including young adult women under the age of 21, unconvicted and unsentenced women, and sentenced women (including some serving life sentences).

23. Care UK provides healthcare services. There are daily GP sessions from Monday to Friday, with out of hours provision for other times. Three primary nurses and a healthcare assistant are on duty during the day, reducing to one nurse and healthcare assistant at night. Care UK provides mental health services.

HM Inspectorate of Prisons

24. The most recent inspection of Foston Hall was in February 2019 and the Chief Inspector's overall judgement was that it was a good report about a good prison. Inspectors found that most prisoners at Foston Hall felt safe and that violence was rare and incidents minor. However, Inspectors found that when incidents did occur, investigations and support for prisoners needed improvement. Inspectors found that paperwork on the application of incentives and earned privileges (IEP) scheme was scant and provided little evidence of board decisions, patterns of behaviour, clear targets or case reviews.

25. Inspectors noted that incidents of self-harm were very high. They found that managers and staff displayed a good knowledge and understanding of the complexities of prolific self-harmers, but analysis of data was not used to develop an effective whole prison approach to reduce the overall number of self-harm incidents. Inspectors noted that the quality of ACCT documents was variable, with evidence of good practice as well as the need for improvements such as a need for better tailored caremaps.

26. Inspectors noted 74% of prisoners reported having a mental health problem. Inspectors found that the mental health team provided an improved range of low-level interventions, while prisoners with a high level of need were managed well and had access to psychiatric support.

Independent Monitoring Board

27. 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 30 November 2018, the IMB reported a slight increase in the number of prisoners' complaints categorised as 'staff/prisoners' concerns including bullying'. The IMB noted evidence of bullying of vulnerable prisoners although they also found that staff were proactive in dealing with incidents of bullying.

Previous deaths at HMP/YOI Foston Hall

28. Ms Hart was the third prisoner to die at Foston Hall within the last two years. Of the previous deaths, one was self-inflicted, and the cause of the other death was unascertained. Our investigation into the other self-inflicted death found that conflict between prisoners was poorly managed.

Assessment, Care in Custody and Teamwork

29. Assessment, Care in Custody and Teamwork (ACCT) is the care planning system the Prison Service uses for supporting and monitoring prisoners assessed as at risk of suicide and self-harm. The purpose of the ACCT process is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Levels of supervision and interactions are set according to the perceived risk of harm. There should be regular multidisciplinary case reviews involving the prisoner anticipating when they will occur.

30. 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. Guidance on ACCT procedures is set out in Prison Service instruction (PSI) 64/2011.

Earned Privilege Scheme

31. Each prison has an Incentives and Earned Privileges (IEP) scheme which aims to encourage and reward responsible behaviour, encourage sentenced prisoners to engage in activities designed to reduce the risk of reoffending and to help create a disciplined and safer environment for prisoners and staff. Under the scheme, prisoners can earn more money in prison jobs and wear their own clothes. There are three levels: basic, standard and enhanced.

Key Events

32. On 16 August 2019, Ms Saria Hart was remanded in prison custody, charged with burglary and wounding with intent, and sent to HMP Foston Hall. This was not her first time in prison.

33. Before Ms Hart arrived at Foston Hall, the escorting agency (GEOAmey) telephoned the prison to tell them that there was a self-harm alert for Ms Hart. The custody sergeant at Staffordshire Police Station had written in Ms Hart's Person Escort Record (PER - a document that accompanies all prisoners when they move between police stations, court and prison, setting out the risks they pose) that when Ms Hart was arrested, she held a knife to her throat and threatened to cut it.

34. An officer took the telephone call from GEOAmey. She wrote the self-harm alert onto the reception booking in sheet, so that the person who saw Ms Hart when she arrived would have been aware of it. The officer did not recall seeing Ms Hart on her arrival at Foston Hall. We have been unable to establish who carried out Ms Hart's reception screening.

35. A nurse carried out Ms Hart's initial health screen. Ms Hart told the nurse that she had anxiety and depression but had no current thoughts of suicide or self-harm. She said she had self-harmed a few years ago, but not within the previous 12 months. She said she had not tried to harm herself in prison (which was incorrect, as she had made self-harm attempts during previous sentences in 2017 and 2018).

36. Ms Hart was allocated to the First Night Unit (where newly arrived prisoners are located). Staff completed a cell sharing risk assessment (CSRA - a document completed to assess a prisoner's risk of sharing a cell with another prisoner) and assessed Ms Hart's risk level as standard, allowing her to share a room.

37. On 17 August, an offender supervisor completed a basic custody screening interview with Ms Hart (BCS1 - used to identify support required in custody and on release). Ms Hart told him she was happy to be remanded in prison and did not wish to seek bail. Ms Hart said she was of no fixed abode, with no next of kin, and was a care leaver. Her two natural children had been adopted, and she had two children from a relationship who she considered her own.

38. On the morning of 18 August, Ms Hart told staff she had seen another prisoner arrive at Foston Hall the night before and was worried about her safety as this prisoner had hit her in the past. Staff moved Ms Hart to F Wing.

39. Later that day, staff saw Ms Hart fighting with another prisoner. An officer placed Ms Hart on a disciplinary charge and started violence reduction monitoring (under Zero Tolerance procedures). (A subsequent investigation found that Ms Hart had acted in self-defence, and she was notified of the outcome on 1 September.)

40. On 19 August, an officer placed Ms Hart on a disciplinary charge after she was found in an unauthorised area of the prison and gave no reason for being there. There is no record of the outcome, and it appears this was not pursued.

41. On 22 August, Ms Hart was moved to T Wing. The officer was assigned as her personal officer. He told the investigator that he knew Ms Hart from previous custodial sentences and that he considered they had a good working relationship.

42. On the same day, a member of staff from the resettlement department, completed Ms Hart's secondary basic custody screening. She noted in Ms Hart's prison record that she had made a referral to the mental health team, but it is unclear if this was done.

43. The officer met with Ms Hart on 1 September. He noted in Ms Hart's prison record that she had applied for a wing job, she was filling her time by writing an account of her life experiences which she wanted to publish, and she had asked if she could go to the prison library for publishing material. The officer noted that Ms Hart had had a couple of verbal disagreements with other prisoners on the wing, and that Ms Hart told him she was not the problem. He noted that one of the prisoners had been moved off the wing and the other was due to be released the next day. He noted that the violence monitoring had been stopped, which was a positive step, and that Ms Hart had been polite to staff since her arrival on the wing.

44. Ms Hart was given a job as a wing cleaner on 3 September. She said having a job was important to her as it kept her occupied, got her out of her room during the day, and provided income to buy goods from the prison shop. Ms Hart did not have any money sent into her and told staff she found it difficult spending so much time in her room.

45. On 8 September, staff gave Ms Hart an Incentives and Earned Privileges (IEP) warning after they saw her vaping (using an electronic cigarette) on the wing. She was aware this behaviour was against the wing rules as she had been told this during her induction to the wing.

46. Ms Hart was known to staff to form sexual relationships with other prisoners, which had caused conflict in previous prison sentences. On 14 September, staff found Ms Hart in her room on the top bunk of the bed with another prisoner, in a half-naked state. Staff reminded them of the prison's decency policy and sent an email to the safer custody department to consider moving one of them to another wing. This move did not take place and Ms Hart and the other prisoner continued to have an on/off relationship. The prisoner told the investigator this caused them to have some disagreements as she knew Ms Hart was in relationships with other prisoners on the wing.

47. The same day, Ms Hart had a verbal disagreement with another prisoner. Someone had put mayonnaise in Ms Hart's trainer, and she blamed the prisoner. On the evening of 16 September, Ms Hart agreed to attend a mediation session with the prisoner. Staff noted in Ms Hart's record that the session had gone well, and both parties had agreed to cause no further issues. Despite this, Ms Hart continued to be unhappy about how staff had dealt with the prisoner, voicing her opinion and dislike of the prisoner to other prisoners on the wing, even after the prisoner left Foston Hall.

48. The officer met with Ms Hart on 29 September. He recorded that she continued to do her work to a high standard. He noted that Ms Hart had had three different roommates over the past two weeks, and had struggled to get on with them, even if

she had asked to share with them. Ms Hart blamed her self-diagnosed obsessive-compulsive disorder (OCD) and asked to be treated as a high CSRA so that she did not have to share. After consulting other departments, the officer noted that Ms Hart would not be classed as high CSRA. He noted that Ms Hart received no visits but maintained family contact.

Events of 3 October

49. On the morning of 3 October, Ms Hart was doing her job as wing cleaner when she interrupted a meeting in the upstairs wing office to return a vacuum cleaner. An officer told the investigator that Ms Hart opened the door with force banging it against the wall, walked in uninvited, threw the vacuum cleaner down and walked out. (A prisoner told the investigator that she and Ms Hart had had a verbal disagreement about their relationship the previous day. The officer told the investigator that Ms Hart was often seen having verbal disagreements with other prisoners, and this sometimes affected her emotional state.)

50. The officer told the investigator that a Custodial Manager (CM) followed Ms Hart out of the office, challenged her behaviour, and asked her what was wrong. Ms Hart shouted abuse at him, and then walked away. The CM stopped following Ms Hart as she appeared to be going to her room. He walked back into the office and shut the door.

51. Staff then saw that Ms Hart had not gone to her room but had returned and was standing outside the office window staring in. After being told by staff to move away and stop staring at them, Ms Hart punched and headbutted the window, and shouted, “Come on!” The officer said Ms Hart appeared to be extremely agitated, she was waving her arms around and appeared to want to provoke a reaction from staff.

52. The officer said staff left the office to talk to Ms Hart, and then decided to walk Ms Hart to her room to de-escalate the situation. Ms Hart initially complied and started to walk with staff in the direction of the stairs. The officer said Ms Hart seemed extremely agitated and would not answer her when she asked what was wrong.

53. When they reached the top of the stairs, Ms Hart sat down. Staff continued to try to persuade her to return to her room, but she refused to move. Staff restrained her to enable them to move her to her room. The officer said Ms Hart struggled during the restraint and kicked and pushed staff. Some staff were injured, including one who needed hospital treatment. The officer said it appeared that Ms Hart had wanted to be restrained, as during the restraint she shouted, “I needed this, I needed this.”

54. After Ms Hart was taken to her room, a nurse was asked to do a medical examination following the restraint.

55. The nurse told the investigator she could not carry out a full assessment of Ms Hart as the officer told her the door could not be opened due to Ms Hart’s agitated state. The nurse looked through the observation panel in the door. She saw Ms Hart pacing up and down in her cell and saw no injuries. The nurse said she tried to get Ms Hart to talk to her, but Ms Hart refused to answer.

56. The nurse said she had to leave Ms Hart to attend to a member of staff who had been injured and was still on the wing. While she was doing this, another prisoner told her that Ms Hart had a small bleeding cut on her eyebrow. The nurse returned to Ms Hart's room. She said Ms Hart seemed quieter. She spoke to her through the door and asked her if she was okay. Ms Hart said she was, and that she was sorry for hurting staff. She said she had wanted to be restrained as it helped release the tension she was feeling, and she just needed a cuddle. She assessed Ms Hart's injuries by looking through the observation panel. She saw a scratch above her eyebrow, which was not bleeding. She advised Ms Hart to clean it.

57. Later that day, staff placed Ms Hart on two disciplinary charges, suspended her from her work, moved her to the basic level of the IEP system, and started violence reduction monitoring.

58. At 11.05 am, staff began hourly monitoring of Ms Hart under segregation procedures. Ms Hart was segregated within her cell under Prison Rule 53 pending the adjudication hearings the next day.

59. At 11.15am, the nurse completed the healthcare algorithm section of the segregation paperwork. She assessed that Ms Hart was fit for segregation, which was signed off by the duty governor at 11.20am.

60. At 1.30pm, staff started ACCT procedures on Ms Hart after she passed a note under her door saying that she planned to take her life by swallowing a blade. At 2.20pm, a Supervising Officer (SO) completed the immediate action plan and set observations at two an hour, and two conversations per shift.

Events of 4 October

61. A business administrator and a trained ACCT assessor carried out an ACCT assessment with Ms Hart at 10.30am. She said Ms Hart engaged well but was visibly upset and agitated. Ms Hart told her she had been bottling things up for the last two weeks and had just exploded. She was having difficulty coming to terms with not being allowed contact with her adopted children, which she thought unfair. Ms Hart said she had no friends. She denied having a relationship with Ms Hanson, but said she wanted to be moved off the wing because of her. She said she had been promised a move to B Wing but had been told this would not happen and was upset.

62. When asked if she wanted to die, Ms Hart answered yes, and said she planned to cut the length of her forearm with a blade. She said she had blades in her room, which she refused to hand over.

63. At 11.30am, a SO chaired Ms Hart's first case review. A nurse, the business administrator and a CM attended. The SO knew Ms Hart from previous prison sentences and described her as a strong character who always had people around her. She knew she had been on ACCT procedures before but was not normally a discipline problem. When asked by the investigator if she was surprised to hear Ms Hart had been restrained the day before she said, "No, as she could get highly strung, or upset, or emotional," but added she was not someone who was always in trouble with staff.

64. The SO said when Ms Hart first entered the room her demeanour appeared low, and she did not initially engage, but as she appeared to relax she told them she had no support and was not happy about being placed on a disciplinary charge and violence monitoring and wanted help to get a job in the kitchen.

65. Staff assessed Ms Hart's risk level as raised (out of low, raised and high), and set observations at two an hour, with one conversation a day. Staff set caremap actions of support for a wing move, referral to healthcare for a review of medication, and bereavement counselling for loss of her children.

66. During Ms Hart's case review, a member of staff opened the door and asked if Ms Hart was ready to attend her disciplinary hearing. The SO told them Ms Hart would be there when they had finished. Shortly afterwards, Ms Hart was taken to the segregation unit for her disciplinary hearing without her ACCT document. The SO said this was because she was still writing up the record of the first case review.

67. At 11.40am, a prison manager found Ms Hart guilty on both charges and gave a punishment of seven days loss of association, 14 days loss of privileges (canteen and use of private cash) and 50% stoppage of earnings.

68. In mitigation Ms Hart wrote a letter in which she said, "I am not excusing my behaviour, however, I am not in a good place at the moment … this incident had been building for a few weeks … I just needed a hug." Ms Hart asked the prison manager to retract her violence reduction monitoring to allow her to come out of her room to socialise as she found it difficult being in her room for long periods of time and asked if she could keep her job as it was her only means of income.

69. Following her disciplinary hearing, Ms Hart returned to the wing and was removed from segregation procedures. Ms Hart was given her lunch, which she ate in her room. Just after lunch, staff removed her television as she was on basic IEP level, so not entitled to one. Ms Hart told the staff she did not mind losing her television but needed to come out of her room to socialise.

70. At about 2.00pm, an officer said she took prisoners outside for exercise, which was due to finish at 3.00pm. Staff brought Ms Hart out at 2.20pm and told the officer that Ms Hart needed to be put back in her room after exercise as she was on basic. The officer told the investigator she saw Ms Hart talking to other prisoners and spoke with her. She said Ms Hart seemed annoyed, but not upset or sad. Ms Hart told her she had been a frequent user of 'mamba' and 'spice' (types of PS) before coming to prison and wanted to move wings due to problems with other prisoners on the wing. The officer said Ms Hart asked about a shower that another officer had promised she could have later that day and she told her she would sort it for her when they went back inside.

71. The prisoner told the investigator that when Ms Hart returned from exercise she was locked in her room, and she went to her door to talk to her. A prisoner said Ms Hart was angry at her and told her to "piss off", so she walked away. She returned a few minutes later and saw Ms Hart sitting at her desk writing, and she appeared to be crying. Ms Hart again refused to talk to her, and she walked away.

72. At 3.30pm, the officer was in the wing office when she noticed Ms Hart had pressed her emergency bell, so went to answer it. The officer said she looked through the

observation panel and saw that Ms Hart was writing at her desk. When she saw the officer at the door, she came to the door, passed a note under the door, and then returned to sit at her desk. The officer said she tried to talk with Ms Hart, but she refused to answer her.

73. The officer told the investigator that she did not read the note until she was back in the wing office. It said:

74. "I am not fussed about basic but losing the right to work is something I am not prepared to do, I have no other sauce of income no private cash, so my wage is significant importance also being in my room all day staring at 4 walls is really going to mess with my mental health…. Officers I'm making you all aware tonight is the night I'm done not being listened to anymore…I'm done I can't do it no more (sic)".

75. The officer said she handed the note to a senior member of staff, as she was not a regular member of staff for the wing, and she had been instructed to do this during her initial training. She said the note was passed around the office for staff to read and was then stapled into Ms Hart's ACCT document.

76. CCTV footage shows that at 4.00pm, the officer carried out an ACCT check on Ms Hart. She returned a short time later and let Ms Hart out for a shower. The officer said she asked Ms Hart if she was okay, and she said "yes", but wanted to know if anything was going to be taken out of her room while she was in the shower. The officer said Ms Hart appeared to be very concerned about this, so she assured her nothing would be taken.

77. After about 10 minutes, the officer checked on Ms Hart in the shower room. She did not enter but told the investigator she shouted in to ask if she was okay, and Ms Hart replied she was. Around 4.15pm, Ms Hart returned to her room after finishing her shower, the officer stood at her door talking with her for a short time. They spoke about Ms Hart losing her job and wanting a wing to move. The officer said Ms Hart showed no signs of being upset or distressed. She said she told Ms Hart to press her bell if she needed anything.

78. At around 4.30pm, CCTV shows a small group of prisoners at Ms Hart's door apparently talking to her through the observation panel. A prisoner told the investigator they had gone to see if Ms Hart was okay. She was at the back of the group but could see Ms Hart was writing at her desk and refused to speak to any of them, so they shut the flap of the observation panel and walked away.

79. At 4.45pm, the officer went to check Ms Hart as part of her ACCT monitoring. The officer told the investigator that when she first looked through the observation panel she could not see Ms Hart but then after scanning the room, she saw Ms Hart was hanging by her toilet cubicle with the cable from her fan around her neck.

80. The officer said she tried to call an emergency code blue, but the radio network was busy. She called out to a nurse, who was on the wing talking to another prisoner, to call a code blue over the radio, and to come and help.

81. The officer said the nurse followed her into Ms Hart's room. The officer held Ms Hart around her waist to take her weight and told the nurse to take and use her 'fish knife' (a tool used by staff to cut through ligatures) to cut the ligature around Ms

Hart's neck. Ms Hart had wrapped a flex cable twice around her neck, so the officer said it was difficult to cut. The nurse cut through one piece, then a second officer, who had responded to the emergency call, cut the remaining cable and staff laid Ms Hart on the floor.

82. By this time a third officer had also responded. The officer said between them they checked Ms Hart for any signs of breathing or pulse, and when they found no signs, the third officer started cardiopulmonary resuscitation (CPR).

83. Two more nurses arrived shortly afterwards. The first nurse brought an emergency medical resuscitation bag with her.

84. The first nurse told the investigator that when she turned the oxygen cylinder on, she and the other nurses noticed it was low, so she ran to the Healthcare Department and returned with three new cylinders. The first nurse said this caused no delay as there was enough oxygen in the original cylinder. The second nurse said Ms Hart was vomiting blood and food during the resuscitation, so they had to keep stopping to clear her airway.

85. Staff continued to give CPR to Ms Hart. At 4.56pm, after using a defibrillator, Ms Hart was found to have a pulse, but was still not breathing.

86. At 4.58pm, the air ambulance arrived at Foston Hall, followed by an ambulance at 5.07pm. The paramedics and doctor continued CPR and managed to get Ms Hart breathing unaided. At 5.20pm, Ms Hart was taken to hospital and placed into an induced coma. She did not regain consciousness and died on 12 October.

Contact with Ms Hart's family.

87. When she arrived at Foston Hall, Ms Hart said she had been in care from a young age and had no next of kin. On 4 October, investigations identified a potential next of kin, but it turned out not to be a close relative. After contacting Ms Hart's most recent probation officer and investigating records held for Ms Hart's sister, staff identified her mother.

88. On 6 October, at 9.30am, Foston Hall contacted Staffordshire Police and asked them to visit Ms Hart's mother's address and leave a note for her to contact the prison. At 12.30pm, Foston Hall called the mobile number provided by Staffordshire Police for Ms Hart's mother and left a message asking for her to call.

89. At 8.30am, on 7 October telephone contact was made with Ms Hart's mother. The prison gave her an update of Ms Hart's condition and offered to cover the cost of transport to the hospital where the prison family liaison officer (FLO), and duty governor would meet her.

Support for prisoners and staff.

90. On 4 October, the duty Operational Manager, debriefed staff closely involved in the care and emergency response for Ms Hart. The staff care team also offered support and alternative support networks.

91. The prison posted notices informing prisoners of Ms Hart's death 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 Hart's death. Listeners (prisoners trained by the Samaritans) were asked to walk the wing and make themselves available.

Post-mortem report

92. The post-mortem examination showed that Ms Hart died from hypoxic-ischaemic brain injury (reduced blood flow to the brain) as a result of hanging.

Findings

Management of Ms Hart's risk of suicide and self-harm.

Reception Screening

93. Prison Service Instruction (PSI) 07/2015, Early Days in Custody, says that all prisoners should be risk assessed for potential harm to themselves, to others and from others, and that prisoners assessed as at risk of suicide and self-harm should have support identified and managed. It says that the PER and any other available documentation must be examined in reception to assess the prisoner's risk of harm to themselves or others. It also says that all newly arrived prisoners must be assessed as part of the reception health screen to assess whether they are at risk of suicide or self-harm.

94. Ms Hart arrived at Foston Hall with a self-harm warning. The PER that arrived with her noted that she had threatened to cut her throat when arrested. There is no evidence that reception staff considered this information or considered starting suicide and self-harm monitoring (ACCT procedures). We would expect details of the reception screening, including consideration of any risk factors for suicide and self-harm, to have been noted in Ms Hart's prison record. However, there is nothing in Ms Hart's record to say that a reception screening was undertaken. A nurse carried out Ms Hart's reception health screen, but there is no evidence that she considered the self-harm warning or the information in the PER.

95. We accept that ACCT procedures were subsequently put in place to support Ms Hart, but they were not started until 3 October, the day before Ms Hart was found hanging. Staff should have considered starting ACCT procedures when Ms Hart arrived at Foston Hall, given her clear risk factors. There was a missed opportunity to put support in place for Ms Hart much earlier, including support for her mental health. We make the following recommendation:

    The Operational Manager and Head of Healthcare should ensure that staff conducting reception assessments always examine and consider the Person Escort Record, and any other documents that arrive with the prisoner, to assess whether the prisoner has any risk factors for suicide and self-harm.

ACCT Management

96. PSI 64/2011, Management of prisons at risk to self, to others and from others (Safer Custody), sets out the procedures (known as ACCT) that must be followed for any prisoner at risk of suicide and self-harm.

97. Prison staff appropriately began ACCT procedures on 3 October, after Ms Hart wrote a note saying she planned to take her life.

98. Staff created a caremap at Ms Hart's first case review. However, it did not include anything about seeking support for her mental health. It also failed to address Ms Hart's access to blades, which she said she still had in her room, and there no measures were put in place to mitigate this risk.

99. The first ACCT case review appears to have been rushed because Ms Hart was required to attend her disciplinary hearing. Ms Hart's ACCT document was not sent with her when she was taken to her disciplinary hearing because the ACCT case manager was still writing up the case review. This is contrary to PSI 64/2011, which says that a prisoner's ACCT document should accompany them when they are moved around the prison so that the receiving member of staff is aware of the prisoner's risk status and can update the ACCT ongoing record.

100. At the disciplinary hearing Ms Hart was found guilty and punished with loss of association, loss of privileges and stoppage of earnings. She had told staff previously that she struggled with having to stay in her cell and not being allowed to associate with her peers, and we consider it likely that the loss of association would have impacted on her level of risk. We consider that staff should have reviewed her risk after she returned from her disciplinary hearing.

101. Ms Hart passed the officer a second note at around 3.30pm on 4 October. It said that she could not cope with the loss of her job and that being confined to her room was going to damage her mental health. We consider that this should have prompted a review of her risk. Just over an hour later, she was found hanging in her room.

102. We make the following recommendation:

- **The Operational Manager should ensure that staff manage prisoners at risk of suicide and self-harm in line with PSI 64/2011, in particular staff should:**
    - **identify caremap actions that are detailed, time-bound and tailored to reduce the prisoner's risk;**
    - **ensure that the ACCT document accompanies the prisoner when they move around the prison; and**
    - **review the prisoner's level of risk whenever there is an event or change of circumstances that could impact on risk.**

Disciplinary Hearing

103. Ms Hart was being monitored under ACCT when she attended her disciplinary hearing. Her ACCT document did not go with her as it should have done. Nevertheless, the paperwork for the hearing does mention that Ms Hart was on an ACCT, so the prison manager who heard the case was aware of this. PSI 05/2018, Prisoner Discipline Procedures (Adjudications), says:

104. "If the charge against the prisoner is proved the adjudicator must consider the appropriate punishment(s), taking into account the seriousness of the offence, local punishment guidelines in relation to that type of offence, the prisoner's previous disciplinary record, the likely effect of the punishment/s on the prisoner (including any health or welfare impact), any mitigation the prisoner may offer and if the punishment and the location of punishment would have a detrimental impact on any member of staff. Adjudicators must consider the risk factors on an open Assessment, Care in Custody and Teamwork (ACCT) plan or an ACCT closed within the last three months."

105. We are not satisfied that the Adjudicator fully considered Ms Hart's risk factors when he heard the charges against Ms Hart and decided on her punishment. We make the following recommendation:

The Operational Manager should ensure that where charges are heard against a prisoner subject to ACCT procedures, the Adjudicator fully considers the prisoner's risk factors on their ACCT plan and records these in the adjudication paperwork.

Segregation

106. On the morning of 3 October, Ms Hart was segregated under Prison Rule 53, pending her disciplinary hearing the next day. She remained in her room on the wing but was still subject to segregation procedures.

107. Later that day, staff started ACCT procedures for Ms Hart. Prison Service Order (PSO) 1700, Segregation, says that prisoners on an ACCT can be segregated but only in exceptional circumstances. It also says that segregation under Rule 53 "can only be used for the period between the alleged offence and the initial hearing. It will not be used as an automatic measure but only where there is real need, such as the risk of collusion or intimidation relating to the alleged offence which segregation of the accused might prevent."

108. Ms Hart's offence was against staff, and it is not clear why staff felt there was a risk of collusion or intimidation of witnesses or other real need to segregate her. Once Ms Hart was subject to ACCT procedures, there should have been a review of whether segregation continued to be appropriate. We found no evidence that a review was done. There is also no evidence that healthcare staff assessed Ms Hart again, to check that she was fit for segregation, after the ACCT procedures were started.

109. Foston Hall's Safety Strategy says, "If an ACCT is opened whilst a prisoner is segregated a new algorithm must be completed, and if the prisoner passes this, the local 'Segregation Review for prisons [sic] on open ACCT or in Post-closure Stage' must be completed as well as the Regional Defensible Decisions document." We are concerned that a new segregation algorithm was not completed in line with policy when ACCT procedures were started for Ms Hart, and we found no evidence of completion of a Defensible Decisions document. We make the following recommendation:

The Operational Manager should ensure that prisoners in segregation are managed in line with PSO 1700, in particular:

Prisoners on an ACCT are segregated only in exceptional circumstances.

Where a segregated prisoner becomes subject to ACCT procedures, a new healthcare algorithm is completed to check that a prisoner is fit for segregation and the appropriateness of continued segregation is reviewed promptly.

Healthcare following a use of force.

110. Prison Service Order (PSO)1600 says:

> "An appropriately qualified healthcare professional (doctor or registered nurse) must be informed whenever force has been used to restrain a prisoner. He or she must examine the prisoner as soon as possible and must complete a F213 in all cases even if the prisoner appears not to have sustained any injuries. The prisoner must see an appropriately qualified healthcare professional within 24 hours of the incident occurring."

111. Ms Hart was seen by a nurse after she was restrained. However, this examination was conducted through the observation flap in the door due to Ms Hart's agitated state, and on the advice from uniformed staff that it was unsafe to enter.

112. We do not consider that a brief look through a cell hatch meets the requirement for a prisoner to be examined by a healthcare practitioner. Where it is not possible to conduct a proper examination immediately after an incident, the prisoner should be seen again by healthcare a few hours later.

The Head of Healthcare should ensure that staff carry out a proper assessment of a prisoner after a use of force incident.

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