Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Ms Emma Kent, a prisoner at HMP/YOI Foston Hall, on 24 July 2023

A report by the Prisons and Probation Ombudsman

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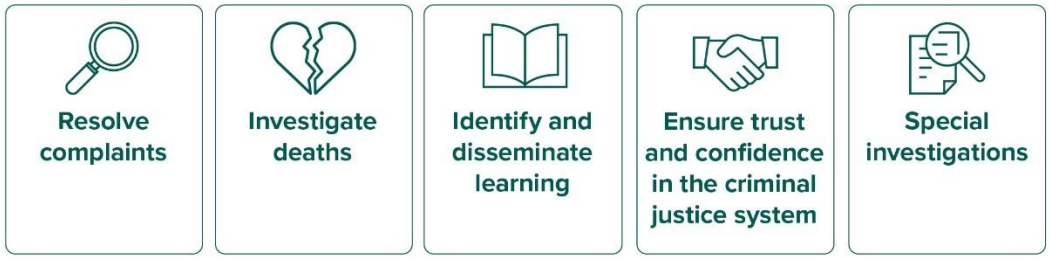
OUR VISION

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 Emma Kent died as a result of mixed drug toxicity from prescribed medication on 23 July 2023 at HMP Foston Hall. She was 36 years old. I offer my condolences to Ms Kent's family and friends.

Ms Kent was a complex prisoner who had a history of using illicit substances and frequently self-harmed in a range of ways and for multiple reasons. Prison and healthcare staff worked collaboratively to try and manage Ms Kent's risk.

The clinical reviewer concluded that the clinical care Ms Kent received at HMP Foston Hall was good and equivalent to what she could have expected to receive in the community. Following advice from pharmaceutical specialists, the clinical reviewer concluded that Ms Kent's medication was prescribed within national guidelines.

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

Adrian Usher
Prisons and Probation Ombudsman **April 2025**

Contents

Summary

Events

1. On 15 July 2015, Ms Emma Kent was sentenced to six years in prison for wounding with intent and was sent to HMP Styal. Ms Kent spent time in secure psychiatric hospitals, but on 27 July 2021, she was remitted back to prison. On 13 December 2021, Ms Kent was released on licence but was recalled to HMP Foston Hall on 21 April 2022, after breaching the conditions of her licence.

2. Ms Kent had a complex physical and mental health history. She frequently self-harmed. Staff monitored her under Prison Service suicide and self-harm prevention procedures, known as ACCT. She had frequent interactions with the prison's mental health team and a psychiatrist and was prescribed several medications.

3. Towards the end of her life, Ms Kent spent almost two months in the prison's Care and Separation Unit after assaulting a member of staff and due to unsettled behaviour.

4. On 21 July 2023, a multi-disciplinary meeting was held and decided that due to Ms Kent's recent period of settled behaviour it was appropriate to return her to a standard wing.

5. On 22 July, Ms Kent self-harmed by cutting her neck with a razor blade. She was taken to hospital, and staff started ACCT procedures. At hospital, she was given a general anaesthetic for surgery. After the operation, hospital staff administered pain relief medication.

6. In the early evening of 23 July, Ms Kent was discharged from hospital. A nurse assessed Ms Kent and dispensed her prescribed medication. Ms Kent seemed very sleepy but presented with no concerns. Staff carried out ACCT checks throughout the night.

7. At 5.34am on 24 July, an OSG and an officer established Ms Kent was unresponsive. They went into her cell, radioed a medical emergency code, and started cardiopulmonary resuscitation (CPR). Staff in the control room called an ambulance.

8. At 6.08am, paramedics arrived at Ms Kent's unit and at 6.36am, confirmed that Ms Kent had died.

9. The post-mortem concluded Ms Kent died of mixed drug toxicity from prescribed medications.

Findings

10. Ms Kent was a complex prisoner and a challenge for healthcare staff and prison staff to manage. All staff worked well together to manage her self-harm which was prolific and unpredictable.

11. The clinical reviewer concluded that the care Ms Kent received at Foston Hall was good and equivalent to what she could have expected to receive in the community.

12. Ms Kent was prescribed a number of medications and received pain relief medication when she was admitted to hospital after she had self-harmed. The clinical reviewer, having taken specialised medical and pharmaceutical advice, concluded that the prescribing of those medications was carried out in line with national guidelines.

13. We make no recommendations.

The Investigation Process

14. HMPPS notified us of Ms Kent's death on 24 July 2023.

15. The investigator issued notices to staff and prisoners at HMP Foston Hall informing them of the investigation and asking anyone with relevant information to contact her. No one responded.

16. The investigator visited HMP Foston Hall on 9 August. She obtained copies of relevant extracts from Ms Kent's prison and medical records, and viewed CCTV footage.

17. The investigator interviewed nine members of staff at HMP Foston Hall on 13 and 14 September 2023.

18. NHS England commissioned a clinical reviewer to review Ms Kent's clinical care at the prison. She and the investigator conducted clinical interviews together. The clinical reviewer sought advice from pharmaceutical specialists regarding Ms Kent's prescribed medications.

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

20. The Ombudsman's office contacted Ms Kent's family to explain the investigation and to ask if they had any matters they wanted us to consider. They asked what medication Ms Kent was given in hospital and for a copy of our report.

21. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

22. The initial report was also shared with Ms Kent's family. They did not find any factual inaccuracies or make any further comments.

Background Information

HMP Foston Hall

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

24. Practice Group Plus provide primary and mental healthcare services. This includes GP clinics and advanced nurse practitioner clinics. There is a mental health team, a psychiatrist and clinical and psychosocial substance misuse support among a range of other services.

HM Inspectorate of Prisons

25. The most recent inspection of HMP Foston Hall was in October and November 2021. Inspectors reported that emerging from the pandemic, the regime had suffered and considered safety outcomes poor. Recorded levels of self-harm were the highest in the women's estate, and the prison had no strategy to reduce self-harm or improve the care for those in crisis. The response to these women was described as reactive, uncaring and often punitive. It was noted that the prison had experienced considerable leadership instability.

26. In August 2022, inspectors carried out a progress review. Progress had been made in a small number of areas and incidents of self-harm had reduced very slightly. It was also noted that four women were responsible for 75% of incidents.

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 November 2023, the IMB reported that a new Governor had been appointed in October 2023 as well as a new Head of Drug Strategy and Head of Safety in the reporting year. A downward trend in the number of self-harm incidents was noted even though rates remained high.

28. The healthcare service continued to face issues with staff recruitment and retention, especially in the mental health team, but progress had been made regarding reducing hospital appointment cancellations, reliable provision of overnight cover by a qualified clinical practitioner, and an increasingly joined-up approach to perinatal care.

Previous deaths at HMP Foston Hall

29. Ms Kent was the third prisoner to die at Foston Hall since July 2020. Both previous deaths were from natural causes.

Assessment, Care in Custody and Teamwork

30. Assessment, Care in Custody and Teamwork (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.

31. 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 identifying support actions is put in place. The ACCT plan should not be closed until all the support actions on the caremap have been completed.

Key Events

32. On 13 February 2015, Ms Emma Kent was remanded to HMP Styal charged with wounding with intent. On 20 July, she was sentenced to six years in prison. On 13 June 2016, Ms Kent was transferred to Edenfield Centre, Mental Health Secure Unit. She was remitted back to HMP Low Newton on 28 November 2016. During her time at Low Newton, Ms Kent committed further offences of arson and assault and was transferred to HMP Downview. On 10 Feb 2020, Ms Kent was sentenced to 34 months in prison for the offences she had committed at Low Newton.

33. Ms Kent had a history of substance misuse (cocaine), poor mental health, suicide attempts and self-harm.

34. On 6 Jan 2021, Ms Kent transferred to Rampton Secure (mental health) Hospital and on 27 July 2021, she was remitted back to prison, and transferred to HMP Foston Hall. On 13 December 2021, Ms Kent was released on licence but was recalled on 21 April 2022 after breaching her licence conditions. She was sent back to Foston Hall.

35. Ms Kent maintained contact with her family during her time at Foston Hall.

HMP Foston Hall

36. A nurse carried out Ms Kent's first night reception screen. Another nurse carried out the secondary screen on 22 April. The nurses documented Ms Kent's complex medical history which included mental health diagnoses of paranoid schizophrenia, Obsessive Compulsive Disorder (OCD), Attention Deficit Hyperactivity Disorder (ADHD), emotionally unstable personality disorder, Aspergers and autism. Ms Kent had physical health diagnoses for epilepsy, thyroid disease and fibromyalgia cause by curvature of the spine.

37. It was noted that while in the community Ms Kent had misused substances in the previous two months and she tested positive for benzodiazepine and cocaine. Ms Kent declined support from the substance misuse team.

38. Ms Kent's prescribed medication included clozapine (for schizophrenia, 275 mgs daily). Clozapine requires recipients to have regular blood tests to ensure the prescribed dose is safe. Her blood test results on the 21 April indicated everything was in the normal range and ongoing monitoring arrangements were put in place to keep her blood and medication levels under review. Ms Kent was also prescribed diazepam (for anxiety, 2 mgs three times a day), promethazine (for psychosis, 25 mgs twice daily), duloxetine (for depression, anxiety and fibromyalgia, 60 mgs daily), mirtazapine (for depression, anxiety and OCD,15 mgs daily) and lamotrigine (for epilepsy,175mgs daily). All her medications were reconciled and prescribed by the GP at the prison. (In June, a forensic psychiatrist at Foston Hall reduced Ms Kent's clozapine prescription to 250 mgs, a day after a routine test of her blood levels.)

39. A nurse referred Ms Kent to the mental health Inreach team (MHIT), and a forensic psychiatrist was informed that Ms Kent had returned to Foston Hall. The mental health team saw Ms Kent within 48 hours. It was highlighted that Ms Kent was vulnerable to being exploited by other prisoners so it was agreed that she would

remain under the care of the MHIT and the psychiatrist due to her complex needs and associated prescribed medication. They saw her regularly and kept her medication under review.

40. During 2022, Ms Kent was monitored under Prison Service suicide and self-harm prevention procedures, known as ACCT, four times, after she self-harmed by cutting herself, made a ligature and inserted and swallowed numerous objects. Healthcare staff advised Ms Kent to go to hospital on these occasions but she said that she preferred to be monitored by healthcare staff at the prison. The psychiatrist noted that Ms Kent was experiencing increased paranoia and acts of deliberate self-harm.

41. Over the months that followed Ms Kent continued to self-harm and tried to overdose with paracetamol. Staff continued to manage her under ACCT procedures, helped her to create a sensory box to manage her emotions and provided on-going support. The psychiatrist noted that Ms Kent's behaviour was emotionally driven and therefore her risk fluctuated with her mood.

42. On 28 February, the psychiatrist reduced Ms Kent's diazepam prescription to 2mgs twice a day from three times a day at Ms Kent's request. (The record does not say why Ms Kent requested a reduction.)

43. On 21 March, staff took Ms Kent to the Care and Supervision Unit after an intelligence report indicated that she had been encouraging other prisoners to harm themselves. Ms Kent's self-harm reduced significantly while she was housed in the Care and Supervision Unit and on 4 April, after a period of settled behaviour, she returned to a standard wing.

44. On 14 April, a Custodial Manager (CM) closed Ms Kent's ACCT against the advice of a nurse from the MHIT who considered that it was too soon. He considered that Ms Kent had stabilised and talked about plans for the future. He told the nurse that he would take advice from other colleagues before reaching a final decision. He spoke to Ms Kent's Prison Offender Manager, who said that Ms Kent had expressed similar thoughts and plans for the future. He closed the ACCT.

45. Two days later, staff reopened the ACCT after Ms Kent cut her neck with a piece of glass. She self-harmed again throughout the ACCT process but was more settled by the end of the month and started weekly sessions with a psychologist. The ACCT was closed on 16 May but was re-opened later that day because Ms Kent made cuts to her neck. She continued to be monitored under ACCT procedures.

46. Ms Kent saw the psychiatrist to discuss her clozapine prescription as she did not feel it was strong enough. The psychiatrist did not increase the dosage because she considered Ms Kent had been prescribed the correct therapeutic dose. On 11 May, she increased Ms Kent's duloxetine prescription to 60mg twice a day from once a day, because Ms Kent reported back pain.

47. On 27 May, Ms Kent was taken to the Care and Supervision Unit for her own safety after she had attempted to re-cut her neck and had assaulted a member of staff. Case reviews and care and supervision meetings were held regularly to ensure that it was still appropriate for her to remain on the unit.

48. On 7 June, a Supervising Officer (SO) closed the ACCT after he consulted a nurse and Ms Kent's Prison Offender Manager. Ms Kent was still located in the Care and Supervision Unit and was subject to various segregation reviews, Safety Intervention Meetings (a meeting to discuss prisoners with complex needs) and a Challenge Support Intervention Plan (a plan which provides extra support where risk to self and others is a concern). The psychiatrist kept her medication under review and received additional input from CAMEO (which provides specialised therapeutic workshops for women with personality disorders). Ms Kent had not self-harmed for several days.

49. On 6 July, Ms Kent asked the psychiatrist to increase her medication. The psychiatrist noted that Ms Kent remained a high risk of impulsive acts of significant self-harm and violence despite extensive therapeutic input in the past. She did not consider there was any immediate increased risk, so she did not increase and had no plans to change Ms Kent's medication. The MHIT continued to have regular contact with Ms Kent while she was in the Care and Supervision Unit and her behaviour settled considerably.

50. On 19 July, a Safety Intervention Meeting was held and attended by 26 members of staff including the Head of Safety and three members of the mental health team. The meeting discussed a number of priority prisoners including those who were in the Care and Supervision Unit. It was noted that Ms Kent had settled and was no longer suitable for the Unit. A prison manager started arrangements for her reintegration to a standard wing and looked into alternative prisons, as staff thought a fresh start might be a good option for her.

51. On 21 July, a nurse saw Ms Kent on the Care and Supervision Unit. She noted she was well kempt and engaged well. Ms Kent said that she was coping, exercising in her cell and going to gym sessions. She had been trying to follow a routine and was sleeping well once she got to sleep. She said she had no real concerns although a potential prison move worried her a little, but minor issues with peers were not bothering her. She said that she was taking her medication and had no problems with it. That day, Ms Kent was housed back on T wing. She continued to be monitored under the Challenge Support Intervention Plan.

52. On 22 July, at 12.20pm, Ms Kent self-harmed by making a significant cut to her neck with a razor blade. She told staff that she did it because another prisoner, who was previously a friend, was nasty to her. Ms Kent told staff she could have killed herself if she had wanted to, but did not, and handed them the razor blade. An officer opened an ACCT and, at 2.30pm, Ms Kent was taken to hospital by taxi.

53. At 1.00pm, a SO completed the Immediate Action Plan and set two observations per hour. Staff restricted Ms Kent's access to razors to reduce risk of further harm to herself in line with the local policy.

54. Ms Kent was admitted to hospital as an inpatient and was prepared for surgery for the neck wound. Ms Kent was given morphine (fentanyl 75 mcg) as part of her general anaesthetic medication. After surgery, hospital staff gave her 20 mgs of oral morphine for post-surgery pain relief. The hospital did not give Ms Kent any of her already prescribed medications.

55. Ms Kent remained in hospital until Sunday 23 July. Before being discharged, hospital staff gave her 30 mgs of codeine for pain relief.

56. At approximately 6:50pm, Ms Kent arrived back at Foston Hall. Prison staff did not tell healthcare staff that Ms Kent had returned to prison as they should have done, but a nurse had already checked with the hospital and knew that Ms Kent had been discharged.

57. At 7.00pm, a nurse saw Ms Kent in her cell and carried out a full set of observations, all of which were in the normal range. She did not complete a NEWS 2 as she should have done. (National Early Warning Score 2 combines the six physical observations of respiration rate, blood pressure, temperature, pulse rate, blood oxygen level and conscious level or new confusion to identify acutely unwell patients.) Ms Kent told the nurse that she was very tired. The nurse knew that Ms Kent liked to sleep on her cell floor and that officers would be checking her twice an hour in line with the ACCT plan.

58. The nurse did not administer any further codeine as a prison doctor, or a nurse practitioner would need to prescribe it and none were available until the next day. Ms Kent asked for some oral morphine, but the nurse did not give her any for these reasons and because she was not presenting as in pain. The nurse gave Ms Kent her other prescribed medications which at that time was clozapine 250mgs, duloxetine 60mgs, promethazine 35mgs, lamotrigine 175mgs and diazepam 2mgs.

59. Usually, staff would hold an ACCT case review when a prisoner came back from hospital. However, because of the time of day, staff were not available for a multidisciplinary review. A SO set up a review for the next morning and carried out a well-being check that evening. He spoke to an officer on Ms Kent's unit to see if there were any concerns about her and checked her prison record. He noted her episode of self-harm which had led to her hospital admission.

60. The SO went to see Ms Kent in her cell on T wing. Ms Kent told him that she had had a bad couple of weeks and wanted to sleep. It was clear to him that the medication had made Ms Kent drowsy. She talked to him a little but she was primarily concerned with getting some sleep. He knew Ms Kent and was familiar with her fluctuating moods. He was confident she would tell him if she needed more support. He was content that the observation regime of two observations an hour was sufficient.

61. An Operational Support Grade (OSG) arrived at the prison at 7.45pm to start his 8.15pm night shift. The Night Orderly Officer told the OSG that Ms Kent had just been discharged from hospital after an episode of self-harm. The OSG went to T wing and an officer gave him a handover. He said Ms Kent was heavily medicated and, as such, unlikely to be much trouble that night. The officer said she was on two observations an hour.

62. Staff completed all the ACCT checks in accordance with the plan. The OSG recalled that, at one point, Ms Kent appeared to have fallen asleep at her desk but that later on she had moved to the floor to sleep next to her bed.

63. Although Ms Kent had not put anything down on the floor to sleep on, her positioning did not suggest to the OSG that she had fallen there. He said it was not

uncommon for prisoners to sleep on the floor with or without coverings or anything to lie on. Ms Kent was on her side with her hands underneath her head. He could see the rise and fall of her chest and on occasion, heard her snoring. She changed position throughout the night.

Events of 24 July

64. Shortly before 5.30am on 24 July, the OSG checked Ms Kent and noticed her beathing was shallower than it had been before. He knocked on her cell door, but she did not wake up (although she was still breathing and there were no other signs of distress). He was due to check on another prisoner who had number of issues throughout the night. The other prisoner had hidden herself from view and the OSG asked a female colleague to see if she was using the bathroom. Officer A attended and confirmed that the other prisoner was in her bathroom, alive and well.

65. The OSG asked Officer A how familiar she was with Ms Kent's sleeping patterns because she appeared to have been sleeping very heavily and snoring and now her breathing seemed much quieter. She confirmed this was usual for Ms Kent, but he asked her to come to the cell with him for a second opinion.

66. At 5.34am, Officer A banged on Ms Kent's door twice and called her name, but she did not respond. She and the OSG went into the cell, and she shook Ms Kent but did not get a response. The OSG felt for a pulse and there was none.

67. At 5.35am, Officer A radioed a code blue and started CPR. Control room staff called an ambulance.

68. At 5.39am, a healthcare assistant and a nurse arrived at Ms Kent's cell. Ms Kent was clammy to touch, but her jaw was clenched and there was vomit around her nose and mouth. The nurse attached a defibrillator which advised no shock. Healthcare and prison staff continued with CPR. The first paramedics arrived at the prison at 6.01am, and reached Ms Kent's unit at 6.08am, and took over. At 6:36am, paramedics confirmed that Ms Kent had died.

Contact with Ms Kent's family

69. Following Ms Kent's death, the prison was unable to appoint a family liaison officer (FLO) because all three FLOs were on annual leave and rest days. The prison contacted HMP Stafford for assistance. That day, the Governor of Foston Hall, a chaplain from the chaplaincy team at Foston Hall and a FLO from HMP Stafford went to Ms Kent's mother's address to break the news of her death. Ms Kent's mother was not at home, so they called her mobile number and arranged to meet her and informed her that Ms Kent had died. They offered their condolences and support.

70. On 25 July, Foston Hall appointed a FLO. He contact Ms Kent's mother to offer his condolences and continued support.

71. The prison contributed to the costs of Ms Kent's funeral in line with national policy.

Support for prisoners and staff

72. Postvention is a joint HMPPS and Samaritans initiative that aims to ensure a consistent approach to providing staff and prisoners support following all deaths in custody. Postvention procedures should be initiated immediately after every self-inflicted death and on a case-by-case basis after all other types of death. Key elements of postvention care include a hot debrief for staff involved in the emergency response and engaging Listeners (prisoners trained by the Samaritans to provide confidential peer-support) to identify prisoners most affected by the death.

73. After Ms Kent's death, the prison Governor debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

74. A manager contacted the Postvention Samaritans service to support staff and Listeners. They attended the prison on 24 July to provide ongoing support and issued postvention leaflets issued to all units to raise awareness of this support service.

75. The prison posted notices informing other prisoners of Ms Kent'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 Kent's death.

Post-mortem report

76. The post-mortem report gave Ms Kent's cause of death as mixed drug toxicity. The toxicology report highlighted that the combination of diazepam, duloxetine, promethazine and morphine may have caused excess sedation.

Findings

Assessment of risk

77. Ms Kent had a number of risk factors for suicide and self-harm. She had a complex mental health picture and history of prolific self-harm. She was vulnerable to being exploited by other prisoners, but at times, was a high risk to prisoners and staff. Her mental health was robustly managed through frequent interactions with the mental health team and the psychiatrist.

78. Ms Kent was managed under ACCT procedures. Case reviews were held frequently with good multi-disciplinary attendance.

79. The decision to move Ms Kent from the Care and Supervision Unit to a standard wing in July was discussed by a large number of people at a well-attended Safety Intervention Meeting. Ms Kent had been in the Care and Supervision Unit for almost two months and had been very settled with no recent episodes of self-harm. We found that, despite the frequency with which Ms Kent self-harmed, staff continued to react quickly and did their best to keep her safe.

Clinical care

80. The clinical reviewer concluded that the care Ms Kent received at Foston Hall was of a good standard and equivalent to what she could have expected to receive in the community.

81. The clinical reviewer considers that Ms Kent was a very complex patient with multiple mental and physical health conditions which would have been a challenge for any healthcare setting. She found that healthcare staff and prison staff worked well together to care for Ms Kent and reduce her risk of self-harm.

82. When Ms Kent arrived back at the prison from hospital on 23 July, prison staff failed to let healthcare know. The vigilance of a nurse ensured Ms Kent was tracked down and assessed. We understand the Head of Healthcare has since raised this issue with the Security Department and is content that staff are now aware of the correct procedures. So, in light of this, we make no recommendation.

Prescribing

83. Ms Kent was taking a range of medications for her medical conditions. All her prescribed medications were kept under review regularly by the psychiatrist and the MHIT and steps were taken to ensure she was receiving the correct therapeutic doses.

84. On her last admission to hospital, Ms Kent was given fentanyl (75 mcg) which formed part of her general anaesthetic, and after surgery, she received 20 mgs of oral morphine for post-surgery pain relief. On return to Foston Hall, Ms Kent was prescribed her routine medications but was not given any additional pain relief. Ms Kent reported feeling very tired when she returned from hospital but no other concerns were noted and her observations were within the normal range.

85. The toxicologist report indicated that two medications, promethazine and duloxetine were above the therapeutic range. The clinical reviewer confirmed that these medications were prescribed for different conditions and were within therapeutic range.

86. The toxicology report also highlighted that the combination of diazepam, duloxetine, promethazine and morphine may have caused excess sedation. The clinical reviewer sought specialist medical and pharmaceutical advice and concluded that all medications detected within the toxicology report were prescribed for known physical and mental health conditions and the prescribing was in line with national guidelines.

Inquest

87. The inquest hearing into the death of Ms Kent concluded on 11 June 2024. The Coroner gave Ms Kent's medical cause of death as mixed drug toxicity.

88. A jury established that factors probably contributing to Ms Kent's death included that prison healthcare had not been given adequate information or training about clozapine administration following a dosage gap of 48 hours or more, poor communication between prison healthcare and the hospital contributed to a dosage gap of more than 48 hours and that administering a full dose of clozapine at 50 and a half hours after Ms Kent's last dose was probably the most contributory factor of all.

89. The Coroner concluded that Ms Kent died due to the combined effects of medications she had been prescribed in the several days before her death, and it was probably contributed to by the factors outlined in the jury's narrative verdict.

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