Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Ms Anna Craven a prisoner at HMP Foston Hall on 9 August 2015

A report by the Prisons and Probation Ombudsman
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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*

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 Craven was found hanged in her cell at HMP Foston Hall on 9 August 2015. She was 41 years old. I offer my condolences to Ms Craven's family and friends.

Ms Craven had been at Foston Hall only two days before she was found hanged, but had been at the prison before. She was withdrawing from drugs and alcohol, for which she was given appropriate treatment. All new arrivals in prison, particularly those with substance misuse problems are at risk of suicide, but there was little to indicate that Ms Craven was at particular risk and needed increased monitoring. I am satisfied that staff at the prison could not have foreseen or prevented her death.

Although it did not affect the outcome for Ms Craven, there were some deficiencies with emergency procedures which the prison will need to rectify. The investigation also identified a need for better family liaison after a death.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **April 2016**

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Summary

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1. On 7 August 2015, Ms Anna Craven was convicted of theft and sentenced to eight weeks in prison. She was sent to HMP Foston Hall, where she had served previous prison sentences. She had been released from her most recent previous sentence on 22 June 2015. Ms Craven had a history of drug and alcohol misuse, but had no record of mental illness, suicide attempts, or self-harm.

2. At an initial health screen, Ms Craven tested positive for opiates and cocaine. Healthcare staff identified that she was withdrawing from drugs and alcohol and she began appropriate drug and alcohol detoxification programmes. No one considered she was at raised risk of suicide.

3. At 5.55am on 9 August, an officer found Ms Craven hanged in her cell and raised the alarm. Officers and nurses tried to resuscitate Ms Craven until paramedics arrived and took over emergency treatment. At 6.33am, the paramedics recorded that Ms Craven had died. Toxicology tests found that Ms Craven had taken cocaine shortly before she was found hanged.

Findings

4. Staff identified Ms Craven's substance misuse problems when she arrived at Foston Hall and she received appropriate medication to help alleviate withdrawal symptoms. She gave no indication that she was at risk of suicide and we do not consider that prison staff could have predicted or prevented Ms Craven's actions.

5. Staff began appropriate emergency treatment quickly but no one used the required medical emergency code. This, and the lack of a protocol with the local ambulance service, meant there was some delay in calling and despatching an ambulance. While this did not affect the outcome for Ms Craven, such a delay could be crucial in other circumstances. We consider it took too long for the prison to inform Ms Craven's mother of her death. The prison subsequently mishandled arrangements for returning Ms Craven's property and lost some of it. This caused her mother further distress.

Recommendations

- The Governor should ensure that prison staff use an appropriate medical code in an emergency; that radios are in good working order; and that there is an appropriate emergency protocol with the local ambulance service so that they understand that prison staff who request an ambulance might not have immediate detailed information about the patient.

- The Governor should ensure that when a prisoner dies, the next of kin is informed without undue delay.

- The Governor should compensate Ms Craven's mother for the value of the lost property and explain the outcome of the internal investigation to her as soon as this is complete.

The Investigation Process

6. 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 him. No one responded.

7. The investigator visited Foston Hall on 11 August. He obtained copies of relevant extracts from Ms Craven's prison and medical records.

8. NHS England commissioned a clinical reviewer to review Ms Craven's clinical care at the prison.

9. The investigator interviewed eight members of staff and three prisoners at Foston Hall in September and October. The clinical reviewer joined him for four of the interviews.

10. We informed HM Coroner for Derbyshire of the investigation, who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

11. One of the Ombudsman's family liaison officers and the investigator visited Ms Craven's mother to explain the investigation and to ask if she had any matters she wanted the investigation to consider. We have dealt with some matters in discussion and correspondence but Ms Craven's mother also asked the following:

    - Did Foston Hall know that Ms Craven misused drugs?
    - Did Ms Craven receive support from healthcare staff and what medication was prescribed?
    - Where was Ms Craven located in the prison and how did she appear on Saturday 8 August?
    - What were the frequency and times of checks?
    - When and how was Ms Craven found hanged and was there an effective emergency response?
    - Why was there a delay in informing her of Ms Craven's death?
    - Why Foston Hall had appointed a family liaison officer who had spoken to Ms Craven the day before her death?

    Ms Craven's mother received a copy of the initial report. She pointed out one factual inaccuracy. This report has been amended accordingly. Ms Craven's mother also raised a number of issues/questions that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

Background Information

HMP Foston Hall

12. HMP Foston Hall is a closed women's prison serving courts in the Midlands. It holds up to 310 prisoners including unconvicted and unsentenced women, short and long term young adult women under 21 and sentenced women, including some serving life sentences.

13. Derbyshire Health United provides primary healthcare services. There are daily GP sessions Monday to Friday, with out of hours provision at other times. Three primary care nurses, a healthcare assistant and a pharmacy technician are on duty during the day reducing to one nurse and a healthcare assistant from 8.00pm to 7.15am.

HM Inspectorate of Prisons

14. The most recent inspection of HMP Foston Hall was in October 2014. Inspectors found that Foston Hall did a reasonable job in managing its population and there was good support for the many vulnerable women who self-harm. Support for women with substance misuse problems was described as mainly good.

15. Health provision was generally good. There was a high demand for mental health provision and most needs were being met, although primary mental health services needed to improve. Inspectors noted that it was difficult for officers to supervise the administration of medication, as there were two simultaneous queues at the medicine hatches and the space was crowded and cramped. Women reported there were problems with diverted prescribed medications. Security arrangements were proportionate but the positive mandatory drug testing rate was higher than at comparator prisons.

Independent Monitoring Board

16. 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 most recently published report for the year to November 2014, the IMB commented that Foston Hall was a well run prison where staff endeavoured to provide a fair and decent service in a challenging environment.

Previous deaths at HMP Foston Hall

17. Ms Craven's death was the third at Foston Hall since January 2015. Both the previous deaths were apparently self-inflicted; one from a drug overdose, the other hanged herself in the shower room ensuite to the cell. Six weeks after Ms Craven's death there was a further apparently self-inflicted death. This prisoner and Ms Craven both hanged themselves from the shower room door.

Key Events

18. On Friday 7 August 2015, Ms Craven was sentenced to eight weeks in prison for shoplifting. She had been in prison before and most recently had been released from a sentence at Foston Hall on 26 June 2015. During that sentence, Ms Craven had been prescribed methadone to treat opiate dependency.

19. Ms Craven arrived at Foston Hall at 5.55pm. Her escort record, completed at court, noted that she used heroin and crack cocaine, but did not identify any concerns about suicide or self-harm. Officer Jane Hollins completed reception documentation with Ms Craven. An officer recorded that Ms Craven had no thoughts of suicide or self-harm. She did not consider that Ms Craven was at risk of suicide. Ms Craven turned down the opportunity to make a phone call in reception and was given a card allowing £1 credit for a telephone call. (Ms Craven never made any calls from the prison.)

20. At an initial health screen, Ms Craven tested positive for opiates, cocaine and methadone. Ms Craven said that she used three rocks of crack cocaine and three bags of heroin each day, as well as 20mg of prescribed methadone. She said she drank more than ten units of alcohol a day. A nurse noted that Ms Craven showed visible signs of withdrawal, had no mental health issues and had no history of self-harm. Ms Craven did not give consent for healthcare staff to obtain her community GP records. The nurse referred Ms Craven to the doctor and the substance misuse team.

21. Ms Craven told a GP that she used three rocks of crack cocaine, three bags of heroin, and drank six cans of cider, a day. She said she had no mental health problems and had no thoughts of self-harm. The GP recorded that Ms Craven had visible signs of opiate withdrawal, including shakes, and he started her on a methadone maintenance programme, with an initial dose of 10mg, 20mg the next day, 25mg the following day, and then 30mg daily. The GP prescribed a seven-day alcohol detoxification withdrawal programme with an initial dose of 20mg of chlordiazepoxide, 20mg the next day, given in 5mg doses, then to reduce daily by 5mg each day. The GP also prescribed hyoscine butylbromide 10mg (for nausea and vomiting), prochlorperazine 3mg (for nausea), ibuprofen and paracetamol. He asked healthcare staff to check Ms Craven twice a day and that nurses should give her medication.

22. At approximately 8.20pm, Ms Craven was given a single cell in the prison's remand wing, which also serves as the induction wing. All the cells on the wing have a shower and toilet ensuite, with an internal door for privacy. An officer recorded in Ms Craven's prison record that she had been at Foston Hall before and had been released just six weeks earlier. Ms Craven said that she knew the prison and the regime and had no thoughts of harming herself.

23. At 10.37pm, a nurse gave Ms Craven her detoxification medication through the hatch in her cell door.

Saturday 8 August

24. Staff at Foston Hall do roll counts (a security check to establish all prisoners are present) before and after each change of shift with an additional check sometime between 1.00am and 3.00am. Night staff are also required to check two cells on a random basis every 30 minutes between 10.00pm and 6.30am. In addition, new prisoners are checked every 30 minutes on their first night. Records show that staff checked Ms Craven every 30 minutes and no one raised any concerns.

25. At approximately 10.00am, a Supervising Officer (SO) spoke to Ms Craven to collect information such as her national insurance number, next of kin details, and to identify any issues about drugs, alcohol or debt and any immediate health concerns. The SO said she spoke to Ms Craven for about 15 to 20 minutes, but Ms Craven did not want to engage and spent most of the time with her head on the table. Ms Craven said that she felt unwell as she was withdrawing from drugs and she just wanted to go back to her cell to lie down.

26. At 11.20am, a nurse saw Ms Craven for a second health screen. The nurse recorded that Ms Craven had physical signs of withdrawal: she had a moderate tremor when she held out her arms and was restless.

27. At 3.15pm, a healthcare assistant checked Ms Craven and recorded that Ms Craven had physical signs of withdrawal. She had a mild to moderate tremor when she held out her arms, rubbed her joints and muscles and was unable to sit still. Ms Craven said that she felt nauseous but had not been sick.

28. Ms Craven was due to have four separate 5mg doses of chlordiazepoxide. She accepted the morning and evening dose but would not take any at midday and 6:00pm. She received 10mg of methadone at 11.30am and a second dose at 5.52pm.

29. Prisoners are unlocked at Foston Hall throughout the day, apart from a brief period for a roll count at 12.15pm. They are locked in their cells for the night at around 5.45pm. An officer told the investigator that Ms Craven had come out of her cell and socialised with other prisoners during the day. He said that there had been a fire alarm on the wing in the late afternoon and he had gone to every cell to check that all prisoners had been evacuated safely. Ms Craven was asleep at the time and he had to wake her.

30. The investigator interviewed three prisoners who knew Ms Craven. They said that Ms Craven was suffering badly from withdrawal symptoms and she had tried to get additional drugs and medication from other prisoners. They said that Ms Craven had traded her phone credit and tobacco for drugs. The prisoner who was in the cell next to Ms Craven, said that they had last spoken to each other at around 11.00pm. She had a spare washing bowl and Ms Craven said that she would collect the bowl from her in the morning. She said that Ms Craven had seemed fine at the time.

31. At 9.00pm, when Officer A did a roll check, she found that Ms Craven had put her mattress and bedding on the floor. Ms Craven told her she wanted to sleep on the floor because she was withdrawing from drugs and it was cooler. She said her legs were kicking out and, rather then kick the wall, it was better to sleep on

the floor. The officer said it was not unusual for prisoners withdrawing from drugs to sleep on the floor.

32. At 11.30pm, at a random cell check, Officer A said Ms Craven was asleep on the mattress on the floor.

Sunday 9 August

33. At 12.30am, Officer A responded to Ms Craven's cell bell. Ms Craven said she had lower back pain and felt sick. The officer brought a nurse to see Ms Craven and the nurse gave her pain relief and anti-nausea medication. Ms Craven said that, other than her withdrawal symptoms, she felt well. The nurse Page told the investigator that she had no further concerns about Ms Craven.

34. At approximately 1.00am, Officer A did another roll check. When she checked Ms Craven, she was asleep on the mattress on the floor, and she could see she was breathing.

35. At 5.55am, Officer A began the last roll check of her shift. When she reached Ms Craven's cell, she opened the observation panel and saw her suspended by a ligature, made from bedding, over the shower room door. She said she tried to radio for help, but the battery was flat. She therefore ran to get help from a custodial manager and an officer, who were on the wing.

36. The custodial manager radioed for urgent medical assistance but did not use a medical emergency code. The control room recorded the call at 5.59am. The officers went into the cell and cut the bedding from which Ms Craven was hanging. Within a minute, a nurse and a healthcare assistant arrived at Ms Craven's cell. The nurse checked Ms Craven's airway, breathing and circulation but, found no signs of life. She therefore began cardiopulmonary resuscitation. The nurse told the investigator that Ms Craven felt cold and clammy. They attached an automated external defibrillator to Ms Craven but this found no shockable heart rhythm. The nurse asked for an emergency ambulance.

37. Ambulance Service records show that the prison made a 999 call at 6.04am and that paramedics were despatched at 6.12am. The prison control room log recorded that they had first called the ambulance service at 5.59am, but the ambulance service would not prioritise the call because control room staff did not have enough information. They rang again at 6.04am, and asked for an ambulance to attend immediately. At 6.18am, paramedics arrived at the prison and took over the emergency treatment at 6.20am. At 6.33am, they recorded that Ms Craven had died.

Contact with Ms Craven's family.

38. The Governor and a trained family liaison officer went to see Ms Craven's mother at her home at 1.00pm to break the news that Ms Craven had died and offer condolences. In line with Prison Service instructions, the prison contributed to the costs of the funeral. There were some difficulties returning Ms Craven's property. The prison lost Ms Craven's clothing but did not inform Ms Craven's mother until some time later, after we intervened.

Support for prisoners and staff

39. After Ms Craven's death, the Governor debriefed the staff involved in the emergency and offered her support and that of the staff care team. The staff identified issues about flat radio batteries and that the ambulance service would not send an ambulance without further information.

40. The prison posted notices informing other prisoners of Ms Craven's death, and offering support. Staff reviewed all prisoners assessed as at risk of suicide and self-harm, in case they had been adversely affected by Ms Craven's death.

Post-mortem report

41. A post-mortem examination found that the cause of death was hanging. The pathologist noted that toxicology tests had found therapeutic levels of prescribed medication and cocaine in Ms Craven's body. The pathologist concluded that the levels indicated that Ms Craven had taken cocaine shortly before her death.

Findings

Assessment of risk of suicide and self-harm

42. Ms Craven had been in prison several times before and had recently been released from a previous sentence at Foston Hall. She had a history of substance misuse but had no history of suicide attempts or self-harm and there was no record or indication that she suffered from mental illness. A reception officer, nurse and doctor assessed Ms Craven when she arrived at Foston Hall. None of them considered that she was at raised risk of suicide, such that she needed additional monitoring and support using Prison Service suicide and self–harm prevention procedures.

43. Ms Craven did not disclose any further concerns to staff. It appears that she had either brought some drugs into the prison or obtained some from other prisoners but prison staff were not aware of this. We cannot know whether this affected her state of mind.

44. All new arrivals in prison, particularly those with substance misuse problems, are at risk of suicide, but there was little to indicate that Ms Craven was at particular risk and needed increased monitoring. We do not consider that staff at Foston Hall could have foreseen or prevented her actions on 9 August.

Clinical Care

45. A nurse in reception referred Ms Craven to a doctor and the substance misuse team as it was evident that she was withdrawing from alcohol and other illegal substances. A doctor prescribed a methadone maintenance programme and appropriate medication to relieve the symptoms of withdrawal from alcohol and drugs, although Ms Craven chose not to take two doses of medication on 8 August. We are satisfied that Ms Craven received appropriate support for her substance misuse problems.

46. The prison was unable to obtain Ms Craven's community GP records to check for other health issues, as Ms Craven would not give consent to their disclosure. Ms Craven had no history of self-harm or attempted suicide and had given no indication to anyone that she had any suicidal thoughts. The clinical reviewer considered that the standard of care Ms Craven received at Foston Hall was equivalent to the care she could have expected to receive in the community.

Emergency Response

47. PSI 03/2013 *Medical Emergency Response Codes,* issued in February 2013, contains mandatory instructions for efficiently communicating the nature of a medical emergency, ensuring staff take the relevant equipment to the incident and that there are no delays in calling an ambulance. It explicitly states that all prison staff must be made aware of and understand the instruction and their responsibilities during medical emergencies. The PSI also includes a mandatory instruction that the terms of the medical emergency response protocols must be written and agreed in conjunction with the local healthcare commissioner at the prison and the local ambulance trust. The Governor issued an instruction to staff in July 2015 reminding them of the medical emergency codes.

48. When Officer A found Ms Craven hanging she could not use her radio as the battery was flat but Ms Heap was nearby and radioed for help. Although custodial manager did not use the expected medical emergency code the control room called an ambulance immediately. Nurses arrived quickly and administered appropriate emergency treatment. However, the ambulance service would not prioritise the call without further information about Ms Craven's condition. This appears to have led to a five minute delay before an emergency ambulance was despatched.

49. It does not appear that this delay affected the outcome for Ms Craven, as staff responded very quickly to the emergency and the clinical reviewer commented that from the nurse's account it was likely that Ms Craven was already dead when she first reached the cell. However, in other cases, such a delay could be crucial. The prison has a protocol with the local ambulance service but identified a need to make some revisions as a result of the experience in this case. It is important that ambulance call centre staff understand the prison context and that prison control room staff who call ambulances might not have immediate detailed information about the patient. We make the following recommendation:

The Governor should ensure that prison staff use an appropriate medical code in an emergency; that radios are in good working order; and that there is an appropriate emergency protocol with the local ambulance service so that they understand that prison staff who request an ambulance might not have immediate detailed information about the patient.

Liaison with Ms Craven's family

50. Ms Craven's mother wanted to know why a Supervisory Officer (SO) had been the prison's family liaison officer. She considered that this was inappropriate as he had had some dealings with Ms Craven on 8 August. There is a requirement for prisons to have a nominated member or member of staff to liaise with family members, although this is a voluntary role. The SO was the only trained family liaison officer at Foston Hall at the time and was very experienced. We consider that it was reasonable for her act as the family liaison officer.

51. Ms Craven's mother was concerned about the length of time it had taken to inform her of her daughter's death. Prison Rule 22 states that the when a prisoner dies, the governor should inform next of kin "at once". Prison Service Instruction 64/2011 required that where possible, the family liaison officer and another member of staff should visit the next of kin in person and that this should be done quickly to ensure that the prisoner's family does not hear of the death by other means.

52. It took prison staff over six hours to inform Ms Craven's mother of her death, although she lived just about 30 miles from the prison. The prison first contacted Derbyshire Police to verify Ms Craven's mother's address. The Governor and family liaison officer did not leave the prison until midday, and met the police who then escorted them to Ms Craven's mother's home. While we accept that prisons should undertake checks to ensure that staff are safe when making such visits, we consider that there was too long a delay in informing Ms Craven's mother and

this was not given the priority which Prison Rules require. We make the following recommendation:

The Governor should ensure that when a prisoner dies, the next of kin is informed without undue delay.

Return of property

53. Ms Craven's mother told us that she had received some of Ms Craven's possessions from Derbyshire Police, but had not received the remaining items of property from Foston Hall. PSI 64/2011 contains a mandatory instruction that "following police authorisation, arrangements must be made to hand over the prisoner's personal possessions and monies to the appropriate person".

54. The Head of Residence and Safety at Foston Hall told the investigator that Ms Craven's possessions had been removed from the cell but had then gone missing. She said that the Governor had ordered an internal investigation to try and establish where Ms Craven's possessions were, but they have not been able to find the missing items. The prison did not tell Ms Craven's mother this or respond to her enquiries. This caused her additional distress after the death of her daughter. The prison did not respond to Ms Craven's mother about this until 15 weeks after she had first raised the issue with them, and not until our family liaison officer intervened. We consider that this was disrespectful.

55. At the time this report was issued we were told that there was an ongoing investigation at the prison into the loss of Ms Craven's property, but no conclusion had been reached. We consider it unlikely that the property will be found over six months after Ms Craven died. Although we understand that financial compensation cannot fully recompense families in these circumstances, we make the following recommendation:

The Governor should compensate Ms Craven's mother for the value of the lost property and explain the outcome of the internal investigation to her as soon as this is complete.

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