

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Ms Charlotte Nokes a prisoner at HMP Peterborough on 23 July 2016

**A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE**

Our Vision

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

Our Values

We are:

Impartial: *we do not take sides*

Respectful: *we are considerate and courteous*

Inclusive: *we value diversity*

Dedicated: *we are determined and focused*

Fair: *we are honest and act with integrity*



© Crown copyright 2015

This publication is licensed under the terms of the Open Government Licence v3.0 except where otherwise stated. To view this licence, visit nationalarchives.gov.uk/doc/open-government-licence/version/3 or write to the Information Policy Team, The National Archives, Kew, London TW9 4DU, or email: psi@nationalarchives.gsi.gov.uk.

Where we have identified any third party copyright information you will need to obtain permission from the copyright holders concerned.

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 Charlotte Nokes died on 23 July 2016 while a prisoner at HMP Peterborough. The post-mortem was inconclusive. She was 38 years old. I offer my condolences to Ms Nokes' family and friends.

Ms Nokes' case highlights how difficult it is to manage and care properly for vulnerable mentally ill people who display challenging behaviour in prison. In the circumstances, it is commendable that the investigation largely found that the healthcare she received and the support given to manage her risk of suicide and self-harm were appropriate. However, even without evidence of any bearing on her death, I have some concerns over the prison's extensive use of segregation for Ms Nokes and the response to her apparent illicit substance abuse, including the need for better sharing of information between healthcare and discipline 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.

Nigel Newcomen CBE
Prisons and Probation Ombudsman

July 2017

Contents

Summary	1
The Investigation Process	3
Background Information	4
Key Events	6
Findings.....	11

Summary

Events

1. In January 2008, Ms Charlotte Nokes received an indeterminate sentence, with a minimum time in custody of 15 months, for possession of an offensive weapon and attempted robbery. She spent time in several prisons, and was sent to HMP Peterborough on 6 November 2015.
2. Ms Nokes suffered from hormonal imbalance as a result of uterus issues and had a hysterectomy in October 2015. She had a history of substance misuse and mental health issues, for which she received medication and support.
3. Ms Nokes spent a significant period of time in segregation while at Peterborough, although dates are not clear on the records. There are no history sheets detailing Ms Nokes' time in segregation. She found it difficult to integrate into the main prison population.
4. On 22 April 2016, Ms Nokes reported to a psychiatrist that she was self-medicating but this information was not shared further. She appears to have taken trafficked medications and other illicit substances. These and her medications made Ms Nokes drowsy.
5. On 22 July 2016, Ms Nokes appeared to fall asleep in a strange position on her bed, which was not unusual. She was found the next morning during a check on her welfare, in a similar position, stiff and cold to touch. Staff tried to resuscitate Ms Nokes and paramedics arrived. They pronounced her dead at 8.55am.

Findings

6. We agree with the clinical reviewer that the clinical care Ms Nokes received was equivalent to that she could have expected to receive in the community. However, there were some failings in respect of her care and medication management that the prison will need to address. It also appears that not all of Ms Nokes' care and treatment was recorded in her medical records.
7. Ms Nokes was often located in the segregation unit where she was also subject to suicide and self-harm prevention measures. The self-harm prevention measures were clearly documented and, largely, appropriately managed, but the segregation continued for long periods without evidence to indicate that she was seen daily for a healthcare review (as she should have been), or that the prison considered whether there were exceptional reasons that meant she could not be located elsewhere in the prison (as they should have done).
8. While in Peterborough, Ms Nokes reported using illicit substances but it appears healthcare staff did not report this further and the prison took no action to address Ms Nokes' access to illicit substances in response to intelligence suggesting drug misuse. The prison was not able to explain to us what steps it is taking to limit access to illicit drugs and reduce the trafficking of medication.

Recommendations

- The Head of Healthcare at HMP Peterborough should review the medicines management process, and ensure this is supported by an accurate audit trail.
- The Director and HMP Peterborough should ensure that prisoners at risk of suicide or self harm are not held in the segregation unit unless all other options have been considered and excluded and there are fully documented reasons to explain the exceptional circumstances.
- The Director should ensure that there is an effective supply and demand reduction strategy to reduce the availability and use of illicit drugs and diverted medication, including sharing of information between departments.
- The Director should ensure that staff conducting welfare checks note the position of a prisoner, confirm they are breathing, and obtain a response if they cannot establish that the prisoner is alive and breathing during roll check, welfare checks, or ACCT checks.

The Investigation Process

9. The investigator issued notices to staff and prisoners at HMP Peterborough informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
10. The investigator obtained copies of relevant extracts from Ms Nokes prison and medical records.
11. The investigator interviewed three prisoners on 2 September 2016 at Peterborough. He interviewed three members of staff at Peterborough on 9 January 2017.
12. NHS England commissioned a clinical reviewer to review Ms Nokes' clinical care at the prison.
13. We informed HM Coroner for Cambridgeshire and Peterborough District of the investigation. The investigation was suspended until the coroner was able to give us the results of the post-mortem examination. We regret the consequent delay. We have sent the coroner a copy of this report.
14. One of the Ombudsman's family liaison officers contacted Ms Nokes' family, to explain the investigation and to ask if they had any matters they wanted the investigation to consider. Her family had a number of concerns including:
 - They wanted to know whether her care and medication for her mental health issues was appropriate.
 - They wanted to know if prison staff completed the relevant checks and whether Ms Nokes could have been found any earlier.
 - They wanted to know more about the emergency response.
15. The initial report was shared with HM Prison Service (HMPPS). HMPPS did not find any factual inaccuracies.
16. Ms Nokes' family received a copy of the initial report. They did not raise any further issues, or comment on the factual accuracy of the report.

Background Information

HMP Peterborough

17. HMP Peterborough is privately operated by Sodexo Justice Services. It holds men and women in separate sides of the prison. The women's side of the prison holds over 300 women. There is 24-hour healthcare provision

HM Inspectorate of Prisons

18. The most recent inspection of the women's side of HMP Peterborough was in June 2014. Inspectors found that the standard of healthcare services was variable. Although women could see a GP shortly after arrival, reception and secondary health screenings did not adequately assure inspectors that all health risks were identified. Well Women services were very good and women prisoners had reasonable access to the nurse triage clinic and GPs, including a female GP. Care for women with long-term conditions was developing. Inspectors considered that the purpose of the inpatient unit was unclear.

Independent Monitoring Board

19. 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 March 2016, the IMB reported that the healthcare unit continued to offer appropriate support to residents. The Health Promotion Action Group met regularly to plan awareness raising events for conditions including breast cancer, diabetes and oral health. Prisoners were able to access screening programmes for breast and cervical cancer.

Previous deaths at HMP Peterborough

20. Ms Nokes was the fourth prisoner to die from natural causes at Peterborough since January 2016. There are no similarities with the circumstances of the other deaths.

Assessment, Care in Custody and Teamwork

21. Assessment, Care in Custody and Teamwork (ACCT) is the care planning system the Prison Service uses to support prisoners at risk of suicide or self-harm. The purpose of ACCT 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. Checks should be irregular to prevent the prisoner anticipating when they will occur. Part of the ACCT process involves drawing up a care map to identify the prisoner's most urgent issues and how they will be met. Regular multidisciplinary reviews should be held. The ACCT plan should not be closed until all of the actions on the care map have been completed. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Segregation units

22. Segregation units are used to keep prisoners apart from other prisoners. This can be because they feel vulnerable or under threat from other prisoners or if

they behave in a way that prison staff think would put people in danger or cause problems for the rest of the prison. They also hold prisoners serving punishments of cellular confinement after disciplinary hearings. Segregation is authorised by an operational manager at the prison who has to be satisfied that the prisoner is fit for segregation after an assessment by a member of healthcare staff. Segregation unit regimes are usually restricted and prisoners are permitted to leave their cells only to collect meals, wash, make phone calls and have a daily period in the open air. The female segregation unit at Peterborough has 13 cells.

Key Events

23. On 4 January 2008, Ms Charlotte Nokes received an indeterminate sentence for possession of an offensive weapon and attempted robbery. She spent time in several prisons. Ms Nokes had a previous diagnosis of acoustic neuroma (a benign brain tumour) and suffered from Premenstrual Dysphoric Disorder (PMDD – a severe form of premenstrual syndrome). She had substance misuse problems and mental health issues and was frequently subject to Prison and Probation Service suicide and self-harm prevention procedures, known as ACCT.
24. On 15 October 2014, Ms Nokes was moved to HMP Bronzefield. Doctors prescribed diazepam (for anxiety), depakote (for mania symptoms), mirtazapine (an antidepressant), beclomethasone and salbutamol (for asthma), mebeverine (for abdominal cramps), nafarelin and tibolone (synthetic female hormones for PMDD symptoms), omeprazole (to treat excess stomach acid), and paracetamol (for pain relief).
25. In December, the Parole Board recommended she be considered for transfer to a therapeutic community or a secure hospital. This was again suggested through discussion between a mental health nurse in the prison and a doctor at Ravenswood House Medium Secure Hospital in Hampshire in March 2015, but there is no evidence that these referrals were made.
26. In January 2015, Ms Nokes saw a consultant gynaecologist at hospital for a review of the PMDD, who told her she needed a hysterectomy (a surgical procedure to remove the womb). She was prescribed nafarlin and utrogestan (hormonal medications) but did not always take them as she felt it made her psychiatric symptoms worse.
27. Ms Nokes was moved to HMP Peterborough on 7 April. A mental health nurse reviewed her and recorded that Ms Nokes suffered from borderline personality disorder with severe anxiety. A prison GP saw Ms Nokes the next day and prescribed omeprazole to treat acid reflux.
28. A consultant forensic psychiatrist assessed Ms Nokes on 19 May. She diagnosed a personality disorder but stated she would not offer her more appointments at this stage, because Ms Nokes appeared to be symptom free. Ms Nokes continued to have input from mental health nurses within prison. Over the next two months, Ms Nokes sometimes presented as anxious and agitated, and healthcare staff monitored her regularly in conjunction with ACCT monitoring.
29. On 17 July, the consultant forensic psychiatrist prescribed trifluoperazine (an antipsychotic medication that can be used to treat certain types of anxiety). She then planned to review Ms Nokes about every three weeks.
30. Ms Nokes transferred to Bronzefield on 1 October 2015, for her to have a planned hysterectomy operation at the hospital. She had the procedure two weeks later.
31. On 5 November, Ms Nokes tied a ligature made of bed sheets around her neck and told prison staff that she did not want to go back to Peterborough due to bullying. Staff at Bronzefield opened an ACCT and held a first case review. The

next day, Ms Nokes transferred directly to the care and separation unit at Peterborough. Prison staff held a second ACCT case review shortly after she arrived and documented that she appeared to be in good spirits. The prison planned for her to contact her father, see a GP and to reintegrate into the general prison population. They also planned for mental health staff to assess and review Ms Nokes. Mental and physical healthcare staff reviewed her later that day.

32. Ms Nokes remained in the segregation unit, subject to ACCT management, and healthcare staff saw her frequently for reviews, but these were not daily and there appear to have been 12 separate days when a member of healthcare staff did not see her. On 11 December, prison staff held an ACCT case review alongside a segregation (Rule 25G) review. A Ministry of Justice Deputy Controller, the case manager, the Deputy Head of the female prison, Ms Nokes' mental health worker and a general nurse attended. They formulated a plan to reintegrate Ms Nokes in to the main prison population, and later that day she was moved to a single cell on a wing specifically for prisoners serving long sentences. Prison and healthcare staff continued to manage her ACCT plan.
33. The consultant forensic psychiatrist admitted Ms Nokes to the inpatient unit for risk management and psychological review from 12 to 15 January 2016, because Ms Nokes said she found it difficult to cope. She returned to the wing where, on 12 February, the prison received intelligence that Ms Nokes may have taken heroin with a number of other prisoners. There is no record of any action taken by staff in relation to this intelligence.
34. Ms Nokes' appointed mental health nurse monitored her mood and behaviour frequently. The consultant forensic psychiatrist saw Ms Nokes for regular reviews and she often attended sessions with a prison psychologist. Physical healthcare staff saw Ms Nokes and prison GPs reviewed her prescriptions when required. She remained subject to ACCT procedures, which included care map actions to support her to attend hospital appointments, talk with staff and to continue to see members of the mental health team. A prison manager conducted weekly reviews, which Ms Nokes and representatives from the prison's mental and physical healthcare teams often, but not always, attended.
35. From 21 April, prison staff highlighted concern about Ms Nokes' general presentation, and her mental health worker and the consultant forensic psychiatrist reviewed her. Ms Nokes told the psychiatrist the next day that she had been taking illicit substances, and that these were making her feel over sedated. The psychiatrist did not identify any change in Ms Nokes' level of risk and advised her to continue with her current medication. There is no record that she reported Ms Nokes' reported substance misuse to prison staff, although an intelligence report, dated 25 April, stated Ms Nokes had been self-medicating.
36. The next day, the psychologist cancelled her psychology session with Ms Nokes as she was very sleepy and had slurred speech. Ms Nokes reported that she had taken some subutex (a medication used to treat opiate addiction) that she had found on the floor because it made her feel less 'risky'. There is no evidence that the psychologist shared this information with prison staff or submitted a security report. On 12 May, an intelligence report noted that prisoners had

reported concerns about Ms Nokes not taking her prescribed medication and trading it. Again, it is not clear what, if any, action was taken as a result of this information.

37. The consultant forensic psychiatrist saw Ms Nokes for a review on 19 May and recorded that she appeared sedated, with slurred speech. Ms Nokes reported that piriton (an antihistamine medication) caused this, and denied using illicit substances. The psychiatrist noted that she presented as very upset and offered to admit her to the healthcare inpatient unit but she declined. She stopped Ms Nokes' piriton prescription and reduced her dose of diazepam.
38. ACCT procedures were closed on 9 June, because Ms Nokes reported being much happier and feeling supported. On 27 June, the consultant forensic psychiatrist saw Ms Nokes for a review after prison staff reported increasing concern about her mental state. Ms Nokes received 200mg of zuclopenthixol (an anti-psychotic medication) and the next day, the psychiatrist spoke to Ms Nokes by phone and prescribed 5mg of diazepam.
39. On 2 July, Ms Nokes attempted to jump off the wing landing with a ligature in her hand and prison staff had to restrain her. The prison again placed her on ACCT procedures and managed her accordingly.
40. During a ward round on 14 July, a prison GP told a nurse that nurses had reported concern about Ms Nokes' slurred speech. The medical records show that a prison psychiatrist said he had seen her earlier that morning for a care plan review and would speak to the consultant forensic psychiatrist about slowly reducing her medication but there is no record of this discussion taking place. He later recorded that Ms Nokes had a history of neck pain and requested urgent blood tests. The blood results were normal.
41. On 15 July, a nurse recorded that night staff had reported that they experienced difficulty waking Ms Nokes up for her evening medication. Nurses could not be sure whether Ms Nokes was taking any other medication but felt diazepam may be over sedating her. They informed the mental health worker, as Ms Nokes' key worker. No further action was taken.

Events from Friday 22 July to Saturday 23 July 2016

42. At 6.30pm on 22 July, Officer A conducted an ACCT check and recorded that Ms Nokes was sitting in another prisoner's cell talking. Around an hour later, after lock up, she observed Ms Nokes asleep, seated on her bed, leaning forward. She told us that she could see Ms Nokes breathing and that when she banged on the cell door, she received a verbal response from her. She did not record this in the ACCT log. Over the next 12 hours, another officer checked on Ms Nokes twice an hour, noting in the ACCT log that Ms Nokes 'appears asleep'.
43. On 23 July, at 7.23am, Officer B looked through the observation hatch on Ms Nokes cell door to conduct an ACCT check. She noticed Ms Nokes sitting upright on her bed leaning slightly to one side, with her head facing down, obstructing a view of her face and 'breathing noted'. She told us that it looked as though Ms Nokes had fallen asleep in a seated position and that this was not uncommon for her. At a second check at 7.58am, she noticed that Ms Nokes

remained in the same position and recorded 'on bed snoring'. At 8.12am, she checked on Ms Nokes again and recorded that she was still in a similar position, with her head resting on the bed and had 'stopped snoring'.

44. At approximately 8.35am, Officer A looked through the observation hatch into Ms Nokes' cell and saw her slumped over, face down on her bed. She unlocked the door and called out to Ms Nokes, but she did not respond, so she entered the cell. She shook Ms Nokes' shoulder and noticed that she was very cold and stiff, with one side of her face looking significantly discoloured. She pressed the emergency button on her radio, but it did not appear to work, so she went out onto the balcony and shouted 'code blue' (which indicates that a prisoner is unconscious or not breathing) to Officer B, who was on the landing below. Officer B called a code blue emergency response through her radio at 8.40am. The control room called an ambulance.
45. Officer A returned to Ms Nokes' cell to check her vital signs but could not find a pulse. In the meantime, a Senior Officer (SO) arrived and helped her move Ms Nokes onto the floor. He noted her body was very stiff. They applied defibrillator pads to her chest and started cardio pulmonary resuscitation (CPR). A nurse arrived within minutes and started to put a tube into Ms Nokes airway, but her jaw was too rigid to open. Prison and healthcare staff continued CPR until paramedics arrived at 8.45am. At 8.55am, the paramedics confirmed that Ms Nokes had died.

Contact with Ms Nokes' family

46. At 10am, the prison appointed an officer as the prison family liaison officer. He noted that Ms Nokes' mother, her nominated next of kin, lived over 150 miles away and contacted HMP Lewes and HMP Winchester to ask for assistance. They could not immediately confirm whether they could help, so he made contact with Hampshire Police, who agreed to send a family liaison officer to break the news. After failing to obtain an update from the police, he and another officer left to go to Ms Nokes' mother's home.
47. At around 1.30pm, while en route to Portsmouth, the officer received notification that the police had visited the address listed, but the next of kin no longer lived there. A family liaison coordinator at Peterborough called the contact number listed for the next of kin to obtain an address and decided to tell Ms Nokes' mother over the telephone. At 5pm, both officers arrived at Ms Nokes' mother's address. They offered their condolences and support.
48. The officer provided ongoing support to Ms Nokes' family until her funeral, which took place on 5 August 2016. In line with national policy, the prison contributed towards the costs of the funeral.

Support for prisoners and staff

49. After Ms Nokes' death, a prison manager 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.

50. The prison posted notices informing other prisoners of Ms Nokes 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 Nokes death.

Post-mortem report

51. The post-mortem concluded that the cause of Ms Nokes' death was unascertained. However, the reporting pathologist stated that toxicology tests showed no signs of excess drug usage and that there were no features to suggest her death was due to anything other than natural causes.

Findings

Clinical care

52. The clinical reviewer considered that Ms Nokes had interventions and access to healthcare professionals, in line with what she could have expected in the community. Although a referral to a specialist psychiatric hospital suggested by the Parole Board never happened, Ms Nokes received good mental health care within the prison.
53. There were some failings in following up aspects of Ms Nokes' medicines management. It is not clear from the records, what action was taken when Ms Nokes' medicines may have been over-sedating her. Her medication should have been promptly reviewed. Ms Nokes received some long courses (28 days) of diazepam, and at least one long course of zopiclone, which are both highly addictive and suggested to be prescribed as short courses (two weeks). There is also evidence of poor prescribing and recording practices.

The Head of Healthcare at HMP Peterborough should review the medicines management process, and ensure this is supported by an accurate audit trail.

ACCT procedures

54. Peterborough managed Ms Nokes under ACCT procedures from 6 November 2015 until the 9 June 2016, and then from 2 July until she died. Multidisciplinary reviews were often held with representatives of mental health staff, clinical staff and officers, together with Ms Nokes. The caremaps recorded on the two ACCT documents were updated by staff with Ms Nokes' current concerns and how staff proposed to support her through them. It included times when she reported feeling low and specific concerns such as anxieties about parole hearings, relationship issues and changes in medication.
55. Although there were some occasions when information such as her reporting taking illicit substances for possible self-medication, conversations on the evening before she died, and positions in which she slept were not fully recorded on the ACCT document, Peterborough still monitored her closely and, largely, managed her appropriately.

Ms Nokes' segregation

56. Prison Service Order (PSO) 1700 details the procedures to follow when segregating prisoners. A qualified healthcare professional (nurse or doctor) must complete a Segregation Safety Algorithm (health screen) for all segregated prisoners. The purpose is to make a snap shot assessment of a prisoner's mental health when deciding whether to segregate them. The safety assessment was designed in response to a European Court of Human Rights Judgement in 2001, about the imposition of segregation on a mentally unwell prisoner who self-harmed. The aim is to exclude very mentally unwell, suicidal prisoners from segregation, in all but the most exceptional circumstances.

57. Ms Nokes was located in Peterborough's segregation unit from 6 November 2015, until at least 11 December, although the exact dates are not recorded in the paperwork we received but the ACCT document alludes to this date. Ms Nokes had been located in the segregation unit because of her behaviour in Bronzefield before she arrived and her earlier time at Peterborough. It is noted that she requested to be housed in the unit.
58. Prison Service Instruction (PSI) 64/2011 requires that "prisoners on open ACCT plans must only be located or retained in Segregation Units in exceptional circumstances. The reasons must be clearly documented in the ACCT Plan and include other options that were considered but discounted". The exceptional reasons are required to be listed by the management authorising the segregation on the segregation health screen and in the ACCT document. The ACCT document records she was in the segregation unit as a result of her behaviour and that Ms Nokes did not feel safe on general wings. It does not record any exceptional circumstances for keeping her in the segregation unit or consideration of possible alternative locations, as it should.
59. PSO 1700 states that "a doctor must visit each prisoner in segregation as often as their individual health needs dictate and at least every three days. A registered nurse or healthcare officer must make the assessment on all other days, so that a member of healthcare staff visits the prisoner on a daily basis". During Ms Nokes' periods of segregation, records do not indicate that she was always visited by a health care professional. Peterborough has also been unable to provide any history sheets recording the time Ms Nokes was in their segregation unit.
60. The circumstances of Ms Nokes case highlight how difficult it is to manage and care properly for vulnerable mentally ill people who display challenging behaviour in prison. Prisoners who are the most difficult can also be the most vulnerable and we recognise that their behaviour can also be very damaging to others. Prison staff then have difficult decisions to make about where to hold such prisoners and frequently they are cared for in segregation units when all other options have been exhausted. This makes it all the more important to demonstrate fully that all options have been considered and that procedures designed to safeguard prisoners have been properly followed before segregation is used. We make the following recommendation:

The Director at HMP Peterborough should ensure that prisoners at risk of suicide or self harm are not held in the segregation unit unless all other options have been considered and excluded and there are fully documented reasons to explain the exceptional circumstances.

Drug supply reduction policy

61. The post-mortem examination did not reveal any non-prescribed medications or illicit drugs in Ms Nokes' blood and urine. However, our investigation suggests that she may have obtained and taken illicit drugs while in prison. She reported taking illicit substances, but there is little evidence that anything was done to address this.

62. The prison has a Recovery Strategy to guide the management of prisoners through the identification of drug use, referral to the appropriate services and monitoring and support to maintain a drug free existence. However, the prison has not been able to explain to us its strategy for reducing the availability of illicit drugs within the prison environment, for example through effective searching and use of disciplinary procedures.
63. When Ms Nokes reported taking illicit substances, there was no indication of what action was taken. She was already being seen by many healthcare professionals who were aware of her apparent substance abuse and recorded it, but they did not ensure that prison discipline staff were aware of what Ms Nokes had reported and were able to take action in response. It is also apparent that no action was taken when it appeared that she was over-sedated and it was not clear if this was through the effects of illicit substances, her medication, or their interaction with illicit substances. Staff again need to report such instances, and action needs to be taken. We make the following recommendation:

The Director should ensure that there is an effective supply and demand reduction strategy to reduce the availability and use of illicit drugs and diverted medication, including sharing of information between departments.

Monitoring overnight

64. Officer A said in interview that it was not uncommon for Ms Nokes to sleep in strange positions, but on the morning of 23 July noticed that Ms Nokes was in the same position as she had seen her the night before. This prompted her to enter the cell and check on Ms Nokes. It is likely also, that Ms Nokes was not snoring at 7.58am that morning and as Officer B stated in interview, the noise could in fact have come from another cell nearby.
65. Overnight, another officer checked Ms Nokes twice an hour and recorded the same thing each time 'welfare check, appears asleep'. It appears that through the night Ms Nokes did not change position which might have prompted officers to check on her welfare. While, Ms Nokes was known to sleep in strange positions and be difficult to wake, 12 hours is a long time to not change position and staff do need to be able to satisfy themselves that the prisoner is alive and well, by noting breathing, movement or changes in position. Otherwise welfare checks have no purpose. We make the following recommendation:

The Director should ensure that staff conducting welfare checks note the position of a prisoner, confirm they are breathing, and obtain a response if they cannot establish that the prisoner is alive and breathing during roll check, welfare checks, or ACCT checks.

**Prisons &
Probation**

Ombudsman
Independent Investigations