Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Ms Julie Armstrong a prisoner at HMP Bronzefield on 1 July 2017

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 Julie Armstrong was found unresponsive in her cell at HMP Bronzefield on 30 June 2017, two months after arriving at the prison, and died in hospital the next day. A post-mortem examination found she died of sudden cardiac failure, probably due to underlying heart disease. She was 56 years old. I offer my condolences to Ms Armstrong's family and friends.

Ms Armstrong was in very poor physical and mental health when she arrived at Bronzefield on 1 May 2017 and it would have been extremely difficult for staff to have prevented her death.

Although our investigation found some good care from individual staff, we have identified a number of issues that the prison can learn from. In particular, Ms Armstrong's overall care plan lacked coherence and consistency and this affected the quality of her day to day life. I repeat a recommendation about this made in an investigation into the death of a woman at Bronzefield in 2016.

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 **October 2019**

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Summary

Events

1. On 1 May 2017, Ms Julie Armstrong was remanded to Bronzefield for setting a fire at her home.

2. Ms Armstrong was in generally very poor physical and mental health. Between 1986 and 2011 she had lived in a secure mental hospital, mental health units and hostels before being released to independent living. She needed significant emotional support to manage daily tasks and social carers visited her twice a day.

3. In the community, Ms Armstrong's mental health was managed under the NHS Care Programme Approach (CPA) and this care was transferred to secondary mental health services in prison.

4. Ms Armstrong was managed in the prison inpatient unit for just over half her time in Bronzefield. Initial health assessment was good, her medication was continued and she was taken on to the caseload of the mental health in-reach team.

5. Ms Armstrong received good care from an officer on the remand wing where she spent 16 days after her initial assessment. She was returned to the inpatient unit after she fell in her cell and stayed there for four weeks.

6. On 20 June, she was discharged to a different wing where she was described as self-isolating in a filthy cell. On 24 June, she was taken to hospital with a bruised and swollen eye and a lump on the back of her head.

7. On 25 June, Ms Armstrong returned to Bronzefield after having a brain scan, which showed no serious injury. She was located in the prison's inpatient unit and remained there until she was found unresponsive in her cell on 30 June 2017. She died the next day in hospital.

8. A pathologist gave the cause of death as sudden cardiac failure, probably due to underlying heart disease.

Findings

9. Ms Armstrong had frequent falls at Bronzefield but there was a lack of objective assessment by a doctor to determine if there was an underlying physical cause.

10. Some staff believed Ms Armstrong's falls were acts of deliberate self-harm but they did not begin Prison Service suicide and self-harm monitoring in response as they should have done.

11. Ms Armstrong's care co-ordinator in the prison was unaware that her community mental health records were in her prison medical record and did not read them. When the co-ordinator was subsequently absent for several weeks, the system in operation meant that no one stepped into her role.

12. We consider that much of the care Ms Armstrong received from individual staff at Bronzefield was good, but her overall care planning lacked coherence and

consistency and was not sufficiently developed. This meant that she waited too long for a social care assessment and to be put on the waiting list for the optician, missed several appointments and was unable to cope on a standard prison wing.

Recommendations

- The NHS Health and Justice Commissioner should ensure that prisoners subject to the Care Programme Approach have a documented therapeutic plan with clear objectives and that their care coordinator in the prison meets them regularly to update the plan and records all contact and concerns.
- The Director and Head of Healthcare should ensure that unexpected falls, especially if recurrent, are objectively assessed and appropriately investigated to establish a cause.
- The Director and Head of Healthcare should ensure that all staff who believe they have witnessed an act of deliberate self-harm should begin ACCT monitoring in line with national guidance.

The Investigation Process

13. The investigator issued notices to staff and prisoners at HMP Bronzefield, informing them of the investigation and asking anyone with relevant information to contact her. One prisoner and one ex-prisoner responded.

14. The investigator visited Bronzefield on 10 July 2017. She obtained copies of relevant extracts from Ms Armstrong's prison and medical records and CCTV of the emergency response.

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

16. The investigator interviewed fifteen members of staff, six jointly with the clinical reviewer, one prisoner and one ex-prisoner. She spoke to Ms Armstrong's community social worker by telephone.

17. We informed HM Coroner for Surrey of the investigation. This report was suspended pending the results of the post-mortem report and cause of death. The coroner gave us the results of the post-mortem examination in July 2019. We have sent the coroner a copy of this report.

18. We contacted Ms Armstrong's mother, to explain the investigation. Ms Armstrong's mother asked us to confirm the date of her daughter's imprisonment, which we have done in this report. We have sent her a copy of this report.

Background Information

HMP Bronzefield

19. HMP Bronzefield is a privately managed local prison in Surrey, which holds up to 572 women. It is run by Sodexo Justice Services. Sodexo provides 24-hour primary nursing care across the prison and inpatient care for up to 18 women in a dedicated unit. Secondary mental health services are provided by Central and North-West London NHS Foundation Trust (CNWL).

HM Inspectorate of Prisons

20. The most recent inspection of HMP Bronzefield was in November and December 2018. Inspectors reported "an excellent institution" that was overwhelmingly safe for the majority of prisoners. However, there was evidence that the population had become more challenging since the previous inspection, with many women combining highly complex personal problems and significant mental health needs. Recorded violence had also increased and work was needed to reduce it. Many prisoners reported being victimised by other prisoners.

21. The nurse-led inpatient unit had 18 beds for women needing physical care or mental health support. Officers, nurses and mental health staff provided compassionate, caring support for the patients. Prisoners who needed a social care assessment were seen promptly and the prison had a memorandum of understanding with Surrey County Council.

Independent Monitoring Board

22. 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 July 2018, the IMB reported that the majority of the patients in the inpatient unit had complex mental health issues and the unit was mostly full. The beds were often blocked by those waiting for transfer to a secure hospital.

Previous deaths at HMP Bronzefield

23. Three prisoners died at Bronzefield in the two years before Ms Armstrong's death. One was a self-inflicted death, one involved initial detoxification from illicit drug use in the community and the other was from natural causes. One prisoner has died since, also from natural causes, in September 2018. In our investigation into the self-inflicted death in 2016 we found that overall care planning lacked coherence and consistency.

Care Programme Approach

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

Key Events

25. Ms Julie Armstrong had a long history of mental illness including bipolar affective disorder, paranoid schizophrenia, paranoid personality disorder and borderline personality disorder (also known as emotionally unstable personality disorder). In 1986, aged 26, Ms Armstrong was admitted to Broadmoor high secure mental hospital after burning down her flat. In 1996, she was discharged to a medium secure mental health clinic and then moved between different clinics and hostels until 2011, when she was released to independent living aged 50. She had a significant history of attempted suicide and self-harm from the age of 22. She was managed under the NHS Care Programme Approach in the community.

26. Ms Armstrong also had a number of physical health problems including alcoholism, type 2 diabetes and chronic obstructive pulmonary disease (COPD). Social carers visited her twice a day at home to help with medication and personal care. Ms Armstrong's social worker, said Ms Armstrong's mobility was variable and she was occasionally incontinent. She had falls, but mostly when under the influence of alcohol. Ms Armstrong was able to care for herself but lived chaotically when her mental health was poor, and she needed significant support from carers to ensure she attended appointments, took her medication and did not accidentally overdose, and to provide emotional support.

May 2017

27. On 1 May, Ms Armstrong was remanded to Bronzefield for setting a fire at her home. At an initial health assessment that day, a nurse identified Ms Armstrong's significant physical and mental health issues. A prison GP continued her medications including anti-psychotics and medications for diabetes, asthma, pain relief and insomnia. Ms Armstrong appeared unkempt during her initial assessments and was given a single cell in the prison's inpatient unit pending a mental health assessment.

28. On 2 May, the mental health in-reach team (MHIT) referrals meeting allocated Ms Armstrong to a nurse caseload for assessment. That evening a nurse helped Ms Armstrong have a bath. She also cleaned an abscess on Ms Armstrong's elbow. The nurse made a referral to the prison social services team for social care. Ms Armstrong also told her she could not see well.

29. On 3 May, the nurse spoke to Ms Armstrong's social worker, and asked her to fax more information and any risk indicators to the prison. The next day, the social worker, faxed Ms Armstrong's community mental health care records, including letters from her psychiatrist.

30. On 4 May, a nurse made a comprehensive mental health assessment. She was not aware that Ms Armstrong's mental health record had been received because it was not scanned on to her medical record until 8 May. The nurse recorded that Ms Armstrong was low in mood and had some paranoia about people staring at her. She complained that she did not have her glasses with her in prison. She said she thought she had been sentenced but did not know what for and had no recollection of setting the fire at her home. The nurse decided to take Ms Armstrong onto her caseload and became Ms Armstrong's CPA coordinator in prison.

31. Ms Armstrong was discharged from the inpatient unit and moved to a single cell on Houseblock 2 (the wing for remand prisoners) the next day.

32. A Prison Custody Officer (PCO) said she spent a lot of time with Ms Armstrong on Houseblock 2. Her fingerprint did not work on the biometric pod system (an electronic system with fingerprint access that allows prisoners to order items from the prison shop and to book appointments). The PCO said she took Ms Armstrong to reception several times to try to re-enter her fingerprint on the biometric system, but it would not work. Each week the PCO completed Ms Armstrong's menu choices on paper forms and took them to the kitchen for her. The PCO said Ms Armstrong could walk but "dragged" her legs. She needed a lot of prompting to shower but would do so if encouraged.

33. On 10 May, Ms Armstrong did not attend an appointment with the prison psychiatrist. The same day, she burned her fingers after accidentally pouring hot water over them. On 17 May, she was locked in her cell after an altercation with a Senior Prison Custody Officer (SPCO) and missed her appointment with the assistant psychologist.

34. On 18 May, a nurse referred Ms Armstrong to the prison GP because the wound on her elbow was not healing. On 20 May, Ms Armstrong collapsed and banged her head. She was examined by a prison GP on 21 May but did not have a serious injury.

35. On 22 May, the prison psychiatrist assessed Ms Armstrong and took a detailed history. Ms Armstrong complained of low mood and visual hallucinations. The psychiatrist said she was poorly kempt, argumentative and demanding. Her speech was "pressured" (rapid and erratic) and she persistently interrupted him. He described her as confused and disorientated with poor insight and some low-grade psychotic symptoms. He increased Ms Armstrong's anti-psychotic medication. He planned regular reviews by Ms Armstrong's CPA coordinator and said, if there were any concerns about Ms Armstrong, she should return to the inpatient unit.

36. The CPA coordinator was absent from work on compassionate leave from towards the end of May until the middle of June and none of the planned reviews took place during this period.

37. On 25 May, Ms Armstrong said that she had fallen out of bed and banged her head, sustaining a cut to her forehead. She was re-admitted to the inpatient unit for further observations and a GP appointment.

38. On 26 May, Ms Armstrong did not turn up for her appointment with a prison GP, so the GP went to Ms Armstrong's cell instead. The GP said the cell was flooded. Ms Armstrong lay on her bed refusing to answer questions. Ms Armstrong was unstable and unsettled and the GP decided she should remain in the inpatient unit.

39. On 27 May, a nurse reported that Ms Armstrong's personal hygiene was poor. On 28 May, Ms Armstrong told a nurse that she had removed the dressing on her elbow wound.

40. On 30 May, a PCO reported Ms Armstrong had "thrown herself backwards" to the floor of the inpatient unit lounge, hitting her head. A nurse managed to get Ms Armstrong into her chair. The PCO said that she was adamant that Ms Armstrong had hurt herself deliberately. The nurse said she found a large bump on the back of Ms Armstrong's head and a small amount of blood. Her baseline observations were normal, she was conscious and coherent. Officers escorted Ms Armstrong to hospital by taxi as a precaution. Ms Armstrong refused treatment and was returned to Bronzefield the same day. The nurse took her baseline observations and monitored her regularly as a precaution.

41. On 31 May, a nurse described Ms Armstrong as unsettled, unstable, restless and agitated and decided she was unfit for a court appointment that day. A prison GP examined her head injury. Ms Armstrong attributed her falls to postural hypotension (low blood pressure which can cause people to feel dizzy when they stand up) and denied they were intentional. A nurse checked her blood pressure in both a sitting and standing position but no postural drop was identified.

42. Also on 31 May, a member of staff from Surrey Social Services assessed Ms Armstrong in response to a nurse referral for social care of 2 May. The member of staff from Surrey Social Services said she needed more information but noted that Ms Armstrong could not use the pod system because her glasses were at home. She sent a task on SystmOne asking a support worker to make an appointment with the optician.

June 2017

43. On 1 June, a PCO recorded that Ms Armstrong's hygiene was poor. On 4 June, a prison GP examined Ms Armstrong's eyes which were red and sore. Ms Armstrong said she would like some glasses and the prison GP added her to the optician's waiting list.

44. On 6 June, a nurse noted Ms Armstrong's personal hygiene was poor, despite staff encouraging her. The next day the nurse noted poor personal hygiene and unstable mood. The nurse said Ms Armstrong neglected herself but could self-care if prompted.

45. A prisoner said she arrived on the inpatient unit on 9 June and was there for about ten days. She told the investigator that Ms Armstrong was unsteady on her feet and complained of dizziness and was frightened of falling. She thought Ms Armstrong was isolated and miserable. The nurses were kind to her, but the officers were often impatient and seemed to have decided that she was deliberately throwing herself to the floor. She said she tried to help Ms Armstrong use the pod system but her fingerprint did not appear to be registered on the system. She asked an officer how much Ms Armstrong had in her prison account and made a paper order for her instead.

46. On 11 June, Ms Armstrong asked a healthcare assistant to dress the wound on her elbow.

47. On 13 June, Ms Armstrong refused to have a shower and said she had washed in her cell. A prison GP examined her elbow. He said Ms Armstrong had poor

personal hygiene and there was an offensive smell coming from her cell. Ms Armstrong complained of insomnia and the prison GP said she looked tired.

48. On 15 June, a nurse examined Ms Armstrong after officers reported she had fallen. He found a small bump on the back of her head but no bleeding. The nurse said Ms Armstrong was conscious but slightly confused. Her right elbow was swollen and inflamed with pus beginning to leak from an abscess.

49. On 16 June, a PCO noted that Ms Armstrong had been referred to social care but had not received any yet. She said Ms Armstrong needed help with everyday tasks and repeated herself a lot.

50. Also on 16 June, Ms Armstrong saw her CPA coordinator, who had returned from compassionate leave. She noted that Ms Armstrong had had several falls that she claimed were because of low blood pressure. Ms Armstrong complained of visual hallucinations, insomnia and poor memory. She said she wanted to see the optician and wanted to go home. She planned to review Ms Armstrong weekly and discuss her with a prison GP.

51. On 19 June, a prison GP reviewed Ms Armstrong. Ms Armstrong denied any mental health problems and said her falls were due to physical reasons. She said she was angry about the prison regime and this resulted in her throwing food and banging her head on the walls. The prison GP concluded that there was no psychiatric reason for Ms Armstrong to remain in the inpatient unit. The next day, Ms Armstrong was moved to a single cell on C spur of Houseblock 3.

52. A prisoner lived in the cell next door to Ms Armstrong's. She told the investigator that when she first saw Ms Armstrong she was on the floor and looked like she could not get up. Several officers were impatiently telling her to get up and eventually picked her up quite roughly and returned her to her cell. She also said that the other prisoners treated Ms Armstrong very badly and made fun of her. They often called her 'disgusting' because of her poor hygiene. Ms Armstrong spent a lot of time in her cell and officers took her meals to her because the other prisoners often confronted her in the dining area or refused to sit near her. She said Ms Armstrong appeared oblivious to the bullying and was in a world of her own. She said Ms Armstrong appeared to have difficulty with balance and co-ordination. She witnessed one fall and thought it looked genuine and not deliberate.

53. A PCO was on duty on Houseblock 3 on the days Ms Armstrong was there. He said Ms Armstrong kept to her room but occasionally came out and sat on a chair at the table nearest her door. He said Ms Armstrong fell once every day. He said on one occasion she seemed to "fling herself to the floor". On others she appeared to lose her balance. The PCO said Ms Armstrong's cell smelled extremely unpleasant and she resisted all encouragement to wash. He felt sorry for her and thought she should not be in prison. He told other prisoners off for laughing at her when she fell off her chair.

54. On 21 June, a nurse was called to Houseblock 3 because officers found Ms Armstrong on the floor. When he arrived, Ms Armstrong was sitting in her chair watching TV. She was fully alert and oriented and said she had fallen over. The nurse found no injury.

55. On 23 June, a healthcare assistant was called to Houseblock 3 because Ms Armstrong's cell smelled strongly of urine. The healthcare manager decided to re-admit Ms Armstrong to the inpatient unit but there was no cell available.

56. On 24 June, two nurses examined Ms Armstrong after a PCO noticed her right eye was bruised and swollen shut. The PCO, who was not a regular Houseblock 3, and said Ms Armstrong's cell was in an appalling state. There was food and possibly vomit on the floor and the room smelled strongly of urine and faeces. A nurse said Ms Armstrong's cell was very different compared to when she had been on the inpatient unit.

57. A nurse said Ms Armstrong was very agitated and was rolling around on the bed. There was a "very offensive odour" in the room. Ms Armstrong tried to walk but could not and lay on the floor. She spoke incoherently. A nurse called an ambulance. Ms Armstrong could not explain how she had injured her eye. She had old bruises on her neck and a lump on the back of her head that she could also not explain. When a nurse changed Ms Armstrong's clothes, she noticed she had wet herself, had a rash over her buttocks, groin and thighs and broken skin possibly due to moisture damage. The nurse said it was obvious that Ms Armstrong was unwell and unable to look after herself on the houseblock.

58. On 25 June, Ms Armstrong returned from hospital with antibiotics for cellulitis (an infection of the inner layers of the skin) on her elbow. A head scan had not shown any skull or brain injury. She was taken straight to the inpatient unit. A nurse referred Ms Armstrong for social care again because of her increased confusion and risk of falling.

59. On 26 June, a nurse said the bruising over Ms Armstrong's body was healing gradually. Ms Armstrong denied intentional self-harm or suicidal thoughts. The nurse said Ms Armstrong was presenting with "occasional screaming" and she seemed perplexed and was lying awkwardly.

60. The CPA coordinator saw Ms Armstrong the same day and her case was discussed at the multi-disciplinary meeting. The meeting notes showed Ms Armstrong had isolated herself in a filthy cell for four days on Houseblock 3 before being moved back to the inpatient unit. The meeting concluded that Ms Armstrong should remain on the inpatient unit on the CPA's coordinator caseload. It was again noted that Ms Armstrong had open referrals to the optician and for social care. A nurse agreed to chase up her appointment with the optician.

61. On 27 June, a nurse reported Ms Armstrong was unsettled and paranoid, in low mood, unpredictable, aggressive and threatening. She refused to take her medication. On 28 June, Ms Armstrong went to court. She fell from the bench in her court cell and was taken to hospital. She was transferred back to Bronzefield with antibiotics but no discharge letter.

30 June 2017

62. At about 9.00am, Ms Armstrong told a nurse that she did not want her medication that morning. Shortly afterwards, a PCO escorted Ms Armstrong for a blood test. A PCO took Ms Armstrong her lunch at about midday. She said Ms Armstrong was bleeding from a wound on her head and there was blood on the floor of her

cell. A nurse treated a cut to Ms Armstrong's cheek while the PCO and another PCO changed Ms Armstrong's bed linen and cleaned her room. The nurse said he did not find any other wound to Ms Armstrong's head.

63. A PCO made Ms Armstrong a cup of coffee and another PCO sat with her until lunchtime lock-up at 1.00pm. At about 3.00pm, a PCO asked Ms Armstrong if she wanted some water. Ms Armstrong was lying on her bed and said she did not want any.

64. At 4.05pm, a PCO found Ms Armstrong unresponsive in her cell. She said Ms Armstrong was sitting on her bed with her head to one side and her lips and tongue were blue. Another PCO radioed a Code Blue emergency to indicate that a prisoner was not breathing. A nurse and other nurses arrived quickly and began cardio-pulmonary resuscitation. They attached a defibrillator and gave Ms Armstrong oxygen.

65. Paramedics arrived at 4.25pm and took over. They gave Ms Armstrong adrenaline and were able to restart her heart. Ms Armstrong was taken by air ambulance to hospital. Scans showed subsequently that there was no activity in her brain and she died at 12.56pm on 1 July.

Contact with Ms Armstrong's family

66. Ms Armstrong did not give details of a next of kin when she arrived at Bronzefield. As soon as she was taken to hospital on 30 June, the prison asked the police to help locate her family. The police collected Ms Armstrong's mother from her home and escorted her to see Ms Armstrong in hospital the same day.

67. On 1 July, after Ms Armstrong died, the prison family liaison officer and prison chaplain travelled to Ms Armstrong's mother's house, but she was not at home and they were unable to contact her by telephone. They made contact on 2 July.

68. The prison contributed to the cost of Ms Armstrong's funeral in line with national guidance and staff attended the service.

Support for prisoners and staff

69. After Ms Armstrong was taken to hospital, the Director 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.

70. The prison posted notices informing other prisoners of Ms Armstrong'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 Armstrong's death.

Post-mortem report

71. The post-mortem examination found that Ms Armstrong had had a non-fatal head injury at least 30 hours before she was found collapsed in her cell. The pathologist concluded that Ms Armstrong had a heart condition that was most likely to be at the root of her falls and the cause of her sudden collapse and

cardiac arrest. He recorded the cause of death as cardiac dysrhythmia (an irregular heartbeat) caused by cardiac hypertrophy (a thickening of the heart muscle) and fibro-fatty infiltration of the left ventricle, with a head injury which contributed to but did not cause the death.

72. The clinical reviewer, noted that the post-mortem examination also found a significant tumour in Ms Armstrong's lung which had spread to her lymph nodes. In his opinion, this would have greatly reduced Ms Armstrong's life expectancy.

Findings

Clinical care

73. Ms Armstrong was in very poor physical and mental health. The clinical reviewer concluded that although, overall, Ms Armstrong's care was equivalent to that which she could have expected to receive in the community, there were a number of issues that the prison can learn from. His report also includes recommendations that the Head of Healthcare will wish to address.

74. Ms Armstrong was managed under the CPA in the community and had a comprehensive care plan that included psychiatric oversight and daily social care. Ms Armstrong's community mental health records were requested promptly and received by fax three days after she arrived at Bronzefield. They were scanned in to Ms Armstrong's medical record on 8 May, and reviewed by a clinical nurse practitioner who checked that her prescriptions were correct.

75. However, Ms Armstrong's CPA care co-ordinator in prison, was not aware that Ms Armstrong's community records had arrived and did not read them. She did not see important information passed to her by Ms Armstrong's community care co-ordinator that should have informed Ms Armstrong's care plan in prison.

76. The CPA care co-ordinator planned to review Ms Armstrong regularly. This plan was endorsed by the psychiatrist on 22 May. However, the CPA care co-ordinator was on compassionate leave from late May to mid-June and the planned reviews did not take place.

77. The head of the mental health in-reach team, said that that if a prisoner's designated nurse is away for any reason, the nurse's cases will be covered by the mental health team but on a reactive basis (that is, if the prisoner makes an application to see someone or a need becomes apparent). She was not aware that Ms Armstrong was unable to use the pod system to make applications.

78. Ms Armstrong's very poor mental health (and her inability to use the pod system) meant she was highly unlikely to raise any issues. In addition, her poor mental health meant she did not always co-operate with assessments and missed key appointments at which her needs could have been identified as they arose.

79. Ms Armstrong had at least six falls between 1 May and 30 June. The clinical reviewer said these were well documented and initial treatment, assessment and observation was appropriate. However, he said there should have been an objective assessment by a doctor to determine if there was an underlying physical cause for the falls.

80. At interview, several staff said that Ms Armstrong's falls appeared to be deliberate self-harm. This is an unusual method of self-injury, although Ms Armstrong was noted to have cuts and black eyes as a result. If staff believed her falls were acts of deliberate self-harm, then they should have begun Prison Service suicide and self-harm monitoring procedures (known as ACCT). This did not happen.

81. A nurse recorded that Ms Armstrong could not see well and had asked for help with doing things the day after she arrived at Bronzefield. Two days later she complained that she did not have her glasses. According to staff and prisoners at interview, Ms Armstrong's lack of glasses and inability to use the pod system was widely known. Yet it was some four weeks before staff from Surrey Social Services asked for an appointment to be made for Ms Armstrong to see the optician. Even then her name was only added to the optician's waiting list five days later by a GP.

82. The clinical reviewer said that glasses are essential equipment and their absence may prevent prisoners from integrating effectively. The target waiting time to see an optician at Bronzefield is six weeks. When Ms Armstrong died the longest waiting patient on the list was three weeks, one day. Ms Armstrong spent over eight weeks in Bronzefield and the delay in adding her to the waiting list meant she did not see the optician before she died. We consider this was unacceptable, especially given how early Ms Armstrong raised the issue, how widely it was known that her eyesight was poor and the challenges she faced integrating into prison life.

83. Ms Armstrong could self-care but lived chaotically when her mental health was poor and required significant support from carers to ensure she took her medicine and attended appointments and for emotional support. Surrey Social Services assessed Ms Armstrong four weeks after she arrived. She was not allocated carers at Bronzefield, although we accept that this was mitigated to an extent by her periods in the inpatient unit.

84. We are very concerned that Ms Armstrong was allowed to deteriorate so badly in only a few days on Houseblock 3. It is unacceptable that a very mentally unwell woman should manage to self-isolate in a filthy cell for even this short period. The evidence from staff and prisoners indicates that it was perfectly obvious that Ms Armstrong was unable to cope and was almost certainly incontinent.

85. Despite this, much of the care Ms Armstrong received from individual staff at Bronzefield was good. However, her overall care planning lacked coherence and consistency and was not sufficiently developed. The CPA's coordinator unfortunate and unavoidable absence meant there was no-one with specific responsibility for Ms Armstrong's care to take an overview of her issues and plan her care accordingly.

86. In our investigation into the death of a woman at Bronzefield in 2016 who was also being managed under the CPA, we identified that the care co-ordinator was insufficiently involved in care planning. We do not criticise the CPA coordinator but we repeat our recommendation here.

87. We recommend that:

The Head of Healthcare should ensure that prisoners subject to the Care Programme Approach have a documented therapeutic plan with clear objectives and that their care coordinator in the prison meets them regularly to update the plan and records all contact and concerns.

The Director and Head of Healthcare should ensure that unexpected falls, especially if recurrent, are objectively assessed and appropriately investigated to establish a cause.

The Director and Head of Healthcare should ensure that all staff who believe they have witnessed an act of deliberate self-harm should begin ACCT monitoring in line with national guidance.

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