Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Ms Chantel Grant, a resident of Elizabeth Fry Approved Premises, on 26 September 2019

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 Chantel Grant died unexpectedly on 26 September 2019, after being found unresponsive in Elizabeth Fry Approved Premises (AP). The post-mortem concluded that her death was due to Sudden Unexpected Death in Epilepsy. Ms Grant was 34 years old. I offer my condolences to Ms Grant's family and friends.

Ms Grant arrived in the AP on licence on release from prison on 5 September. On the morning of 26 September, she collapsed in the toilet. Staff could not open the door as Ms Grant had fallen against it. They called the emergency services, who eventually gained access and provided medical aid. Ms Grant died in hospital later that morning.

Post-mortem tests indicated that Ms Grant may not have been taking her epilepsy medication, although AP records show that staff dispensed the medication to her correctly in line with her prescription.

I am satisfied that the AP provided a supportive environment for Ms Grant, and that staff responded immediately when she collapsed on the day of her death. We have not made any recommendations.

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

Sue McAllister, CB
Prisons and Probation Ombudsman **December 2020**

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Summary

Events

1. On 5 September 2019, Ms Chantel Grant was released from HMP Bronzefield on licence to live at Elizabeth Fry Approved Premises. She had a history of drug and alcohol use and had had difficult relationships with some staff and prisoners in custody. She had asthma, bipolar personality disorder and epilepsy.

2. AP staff held Ms Grant's medication and dispensed it to her, in line with her prescription. Ms Grant registered with a local GP. Drug and alcohol tests were negative apart from two occasions: once because of a faulty testing machine and once when Ms Grant had drunk some wine. She was upset that she had drunk alcohol and staff reassured her that she would not be recalled to prison.

3. During the three weeks she spent in the AP, Ms Grant had several arguments with other residents, mainly about use of the television. Staff spoke to her and other residents about the disagreements on each occasion.

4. On 17 September, Ms Grant told staff that she thought she had had an epileptic fit during the night. Staff provided her with an alarm, and arranged for her to see a nurse who was working in the AP that day.

5. On the morning of 26 September, staff spoke to Ms Grant in her room at about 7.00am during a routine check. Shortly afterwards Ms Grant went to the toilet and another resident heard her fall. Staff were unable to get a response from Ms Grant or get into the toilet as Ms Grant had fallen against the door. She did not respond, so they called the emergency services. Paramedics were unable to open the door and had to call the fire brigade. They cut the door open, and paramedics began CPR. They transferred Ms Grant to hospital, where she was declared dead at 9.57am.

Findings

Substance misuse

6. Ms Grant had a history of alcohol and substance misuse. She engaged with the substance misuse worker and was appropriately tested at the AP. There is no evidence to suggest that drugs or alcohol contributed to her death.

Ms Grant's healthcare

7. Staff agreed to hold Ms Grant's epilepsy medication and dispense it to her. Ms Grant asked them to do the same with her asthma inhaler. She registered with a local GP. When Ms Grant said that she had suffered a fit during the night, staff encouraged her to seek medical advice, and provided her with an alarm to call for help if she needed it.

8. Post-mortem tests suggested that Ms Grant had not been taking her epilepsy medication. AP records showed that Ms Grant had been requesting it and was given her medication in line with her prescription, with no missed doses

9. It is the responsibility of residents to manage their own healthcare. We consider that AP staff encouraged Ms Grant to attend to her own health needs.

Ms Grant's relationships with other residents

10. During her time in the AP Ms Grant had several arguments with other residents. Staff were aware of these and took appropriate action, including advising Ms Grant about her own behaviour, and supporting her to respond appropriately to provocation from others.

Emergency response

11. When staff were made aware that Ms Grant had collapsed in the toilet, they reacted immediately. When they were unable to get to Ms Grant to provide medical aid, they called the emergency services. There were no delays in AP staff reacting to the emergency.

The Investigation Process

12. The investigator issued notices to staff and residents at Elizabeth Fry Approved Premises informing them of the investigation and asking anyone with relevant information to contact him. No one responded.

13. The investigator visited Elizabeth Fry Approved Premises. He obtained copies of relevant extracts from Ms Grant's prison, probation, approved premises and medical records.

14. The investigator interviewed four members of staff at Elizabeth Fry Approved Premises in December 2019. He interviewed a further member of staff in January 2020.

15. We informed HM Coroner for Berkshire of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

16. One of the Ombudsman's family liaison officers contacted Ms Grant's aunt to explain the investigation and to ask if she had any matters she wanted the investigation to consider. Ms Grant's aunt asked if Ms Grant was under any strain and whether there had been any conflict with other residents. We have addressed these questions in this report.

Background Information

Elizabeth Fry Approved Premises

17. Approved premises mostly accommodate offenders released from prison on licence and those directed there by the courts as a condition of bail or community orders. Their purpose is to provide an enhanced level of residential supervision in the community, as well as a supportive and structured environment. Residents are responsible for their own healthcare and are expected to register with a GP.

18. Elizabeth Fry House in Reading is run by the Elizabeth Fry Charity, rather than the National Probation Service, and is funded directly by the Ministry of Justice. It is one of six approved premises for women in the United Kingdom. It has 21 rooms and holds up to 24 women. Each resident is allocated a keyworker/offender supervisor. There is also a substance misuse worker and a housing worker.

HM Inspectorate of Probation

19. HM Inspectorate of Probation's annual report was published in March 2019. Its inspection of a sample of Approved Premises had found them to be well run and doing a good job of keeping the public safe.

Previous deaths at Elizabeth Fry

20. Ms Grant was the second resident to die at Elizabeth Fry AP. The previous death, in August 2017, was from natural causes. In our investigation into the previous death we found that the AP had offered a supportive environment, and we made no recommendations.

Key Events

21. In December 2018, Ms Chantel Grant was sentenced to two years imprisonment for various offences, including assault occasioning actual bodily harm. She was released on licence in April 2019, but was recalled to HMP Bronzefield three weeks later. She was released on licence again on 5 September 2019. One of the terms of her licence was that she should live at Elizabeth Fry Approved Premises (AP).

22. Ms Grant had a history of drug and alcohol use, and could be violent. She had difficult relationships with staff and prisoners while in custody. Ms Grant had asthma, epilepsy, bipolar personality disorder and other mental health issues.

23. Information about Ms Grant's medical history was included in her Offender Assessment System (OASys) report, which was part of the referral to the approved premises. The AP were aware that she was prescribed sodium valproate for her epilepsy and sertraline for her depression. On her release, Bronzefield gave Ms Grant a medical discharge summary to pass on to her new GP.

24. Ms Grant arrived at the AP on 5 September. One of the AP's resettlement support officers explained her licence conditions, the AP rules and the drug and alcohol policy. Ms Grant signed agreement to the AP's policies, including the medication contract. Ms Grant was given a drug test and an alcohol breathalyser test, both of which were negative.

25. Staff assess whether residents should hold their own medication, or whether staff should keep it securely and dispense it to the resident in line with their prescription. Staff assessed that they should hold Ms Grant's medication for epilepsy and depression and dispense it to her. Ms Grant asked staff to look after her asthma inhalers, too.

26. Ms Grant settled into life at the AP and registered with a local GP.

27. Ms Grant took a drug and alcohol test on 8 September, which was negative. The same day, Ms Grant told staff that another resident was behaving in an aggressive manner, but she was trying not to react. Two days later, she had another disagreement with a resident and went to her room. When staff conducted AP checks that evening, Ms Grant said that she wanted to go to hospital because her back hurt and asked staff to call an ambulance. Eventually, Ms Grant agreed that she would make a doctor's appointment the following morning. She agreed that staff could check her in the night. There were no further issues.

28. On 11 September, Ms Grant argued with other residents again about the television. She told staff that she had only one day's worth of medication left. The AP contacted Bronzefield and requested a copy of Ms Grant's medical discharge summary, explaining that it was urgent.

29. While staff were making their 10.00pm AP checks, they heard a noise. Ms Grant told them that she had fallen coming out of the shower. She had a graze above her ear, and staff helped her clean it. Staff checked Ms Grant in her room at

11.00pm. Staff checked her again at 1.48am and 4.30am, and she was sleeping and breathing normally.

30. On 12 September, Ms Grant had a key work session with the AP's substance misuse worker. She was encouraged to work with local substance misuse services and took drug and alcohol tests, which were negative. That day, the copy of Ms Grant's medical discharge summary from Bronzefield arrived at the AP. Ms Grant took it to the local surgery and collected prescriptions for her medication.

31. On 13 September Ms Grant's offender supervisor visited her at the AP and they discussed her progress. Ms Grant said that she was frustrated by having to take regular drug tests, but the supervisor explained that it was a positive opportunity to show that she was abstaining. Ms Grant reported that she had some issues with several members of staff and had had arguments with other residents. She also told the offender supervisor about her fall in the shower.

32. The following day, 14 September, Ms Grant saw a keyworker for a key work session. They discussed the drug tests and her disagreements with other residents.

33. On 16 September, a trainee offender manager spoke to Ms Grant on the telephone. Ms Grant said things were going well, but she was frustrated with other residents. Her grandmother's funeral was approaching, which she found upsetting, and she had applied for home leave to attend. That evening, Ms Grant had an argument with other residents about the television.

34. On 17 September, Ms Grant took a drug test, which gave a positive reading for opiates and amphetamines. She was taking co-codamol for her back pain, which accounted for the opiates, but Ms Grant disputed the reading for amphetamines. The drug testing machine later gave unusual results for tests on other residents and was later found to be faulty.

35. Later that day, Ms Grant asked to speak to a member of staff about her arguments with other residents. While she got on with some residents, she felt that others were trying to provoke her. The AP's operations manager told her that she was handing the situation well by not reacting aggressively. Ms Grant agreed to ignore anyone trying to antagonise her.

36. At 7.30pm, staff responded to someone pressing the alarm in the laundry room, and found Ms Grant on the floor. She said that she had tripped, and hurt her knee and ankle. Staff sat with her and gave her an ice-pack. They made sure that she could put weight on her leg. Ms Grant said that she did not need further medical attention.

37. On 18 September, Ms Grant told a resettlement support officer that she thought that she had had an epileptic fit the previous night in her sleep. Ms Grant said she did not want a doctor's appointment. The resettlement support officer suggested that she speak to one of the outreach nurses who attended the AP, but Ms Grant told her she was fine. She said in interview that she was content that Ms Grant appeared well and was behaving normally.

38. Ms Grant talked to the operational manager about her issues with other residents, and the operational manager encouraged her to think about how she responded to disagreements. Ms Grant told her about having an epileptic fit during her sleep. The operational manager gave her a panic alarm so she could alert staff if she needed to. Outreach nurses were in the AP that day and the operational manger arranged an appointment. The nurse told Ms Grant to request a medication review at the next appointment with her GP. Ms Grant made an appointment for that afternoon at the walk-in health centre to collect her new asthma inhaler prescription. Despite staff encouraging her, she did not go to the appointment because she was in bed.

39. On 19 September, Ms Grant saw her keyworker. They discussed the tension with residents. They discussed distractions that she could use when she felt stressed. She said that she was not sure her antidepressants were working, so the keyworker advised her to discuss this with her GP.

40. The following day, 20 September, Ms Grant had an appointment with her GP for repeat prescriptions. When she returned to the AP that afternoon, she was crying. Ms Grant told a resettlement support officer that she had drunk half a bottle of wine and thought she would be recalled to prison. The resettlement support officer gave her a breathalyser test, which gave a low reading. Ms Grant said she wanted to speak to her offender manager about what had happened, and left her a telephone message. She then went to her room. A resettlement support officer spoke to her later in the evening, and she was calmer.

41. On 24 September, Ms Grant saw the AP's substance misuse worker. She engaged well, and they discussed her lapse into alcohol use on 20 September. Her relationships with other residents were improving.

42. On the morning of 25 September, Ms Grant got into an argument with another resident. That morning, a few managers discussed Ms Grant's progress. When Ms Grant joined the meeting, she was rude to one of them, refusing to listen to her. Ms Grant was informed that her application for home leave had been approved.

43. That evening, Ms Grant had an altercation with other residents over the television. A operations manager told her that she intended to issue her with a behaviour contract, but Ms Grant said that she would not sign it. She refused to engage any further, and left the office.

44. Staff carried out AP checks at 10.00pm and 11.00pm in line with policy, and there were no issues relating to Ms Grant at either check.

Events of 26 September

45. On the morning of 26 September, two resettlement support officers carried out the 7.00am morning check around the AP. One of them knocked on Ms Grant's door, and Ms Grant called out that she was fine and did not want anyone to come in. The resettlement support officer explained that she needed to see her, so Ms Grant agreed and she opened the door. Ms Grant was sitting on her bed, and told her that she was fine. She said in interview that there was no obvious

reason why Ms Grant had not wanted staff to go into her room, and there was nothing in Ms Grant's voice or manner that caused her concern at that point.

46. CCTV footage shows that a minute after the two resettlement support officers had left the landing, Ms Grant came out of her room and walked towards the toilets. She was unsteady on her feet. She went into the toilet and, soon after, another resident heard a noise. CCTV shows that three minutes after Ms Grant had gone into the toilet, the other resident went to the office and told the two resettlement support officers that she thought Ms Grant had fallen and she thought she was having a fit as she could hear her shaking.

47. The two resettlement support officers went upstairs and called to Ms Grant, but she did not respond. They unlocked the door from the outside and tried to open it, but Ms Grant had fallen against it and they could not open it more than a few centimetres. They could hear Ms Grant's breathing, which was laboured. One of them telephoned for an ambulance. Ambulance service records show that the call was received at 7.10am. She also telephoned the AP's on-call manager. They asked another resident, who was of small build, to try to get through the gap they had managed to get in the doorway, but she was unable to.

48. Ambulance paramedics arrived at 7.20am, and could hear Ms Grant breathing but could not get into the toilet. They called the fire brigade, and firefighters arrived and cut through the door. At 7.29am paramedics began to treat Ms Grant. They recorded that she was found in a state of arrest and that they started CPR, then transferred her to the ambulance and on to the Royal Berkshire Hospital. She could not be resuscitated and hospital doctors agreed to stop CPR and declared Ms Grant dead at 9.57am.

Contact with Ms Grant's family

49. When Ms Grant died, staff at the Royal Berkshire Hospital told the AP that their Bereavement Team would notify Ms Grant's next of kin. The AP confirmed that this was her aunt. The AP manager wrote to Ms Grant's aunt the following day, and subsequently spoke to her. She arranged to have Ms Grant's belongings couriered to her and arranged for her to visit the AP. In line with guidance, the AP offered a financial contribution to the costs of Ms Grant's funeral. The AP held a memorial service to allow other residents to pay their respects to her.

Support for residents and staff

50. AP staff held group meetings with AP residents twice on 26 September. They were encouraged to use staff or other avenues of support if they felt that they needed to. The AP's chaplain visited the AP on 26 September and offered support to staff and residents. A counsellor was brought to the AP on 27 September to meet any residents who were affected by Ms Grant's death. Two residents who were being monitored as at risk of self-harm had their circumstances assessed to ensure that they had not been adversely affected by Ms Grant's death and could access necessary support.

51. The AP managers spoke to staff in the AP on 26 September. They arranged for workplace support for staff, and counselling was offered to staff if they wanted it. The following week, managers arranged for an external employee assistance

company to come to the AP and hold a critical debrief, and provide support for any staff who felt that they may need it.

Post-mortem report

52. The post-mortem report stated that Ms Grant's death was due to Sudden Unexpected Death in Epilepsy (SUDEP).

53. Toxicology reports indicated that Ms Grant had not been taking her epilepsy medication.

54. SUDEP refers to deaths in people with epilepsy that are not caused by injury or other known causes. Most, but not all, cases of SUDEP occur during or immediately after a seizure. The exact cause is not known, but possible factors include heart failure or pauses in breathing during a seizure. Risk factors may include missing doses of medication.

Findings

Substance misuse

55. Ms Grant had a history of alcohol and substance misuse. During her time at the AP, there was little reason to suspect that she had relapsed. At no point did any staff suspect her of being under the influence of any illicit substances and she engaged with the AP's substance misuse worker. No alcohol or drug paraphernalia were found in her room.

56. Apart from a faulty drug test, Ms Grant only had one positive test for alcohol at the AP. In interview, one resettlement support officer said that if Ms Grant had not confessed to drinking wine, it is unlikely that staff would have detected it. Ms Grant's licence did not prohibit her from drinking alcohol and drinking alcohol did not breach AP rules (although there are rules around it). The breathalyser test showed a very low reading. Post-mortem tests found no traces of alcohol in Ms Grant's system.

57. AP staff appropriately supported Ms Grant's substance misuse needs, and there is no evidence to suggest that drugs or alcohol played a part in her death.

Ms Grant's healthcare

58. The Approved Premises Manual says that residents should understand that they are responsible for their own medication, and that taking it at the right time and in the proper dosage is their responsibility and not that of the AP. Ms Grant signed the medication contract on arrival in the AP. In line with national guidance, the AP has a policy for the retention and distribution of medication for residents who do not hold their medication in their own possession. Ms Grant agreed that staff would retain her medication and dispense it to her, on request, in line with her prescription.

59. AP records show that Ms Grant requested and was given her medication in line with her prescription. However, post-mortem tests indicate that Ms Grant had not been taking her epilepsy medication.

60. AP staff encouraged Ms Grant to register with a local GP, and confirmed with her that she had done so. When Ms Grant was released from Bronzefield she was issued with a medical discharge letter to allow her to request repeat prescriptions from her GP. When she told staff that she was running low on medication and needed this letter (presumably having lost the one issued to her), they requested a copy and ensured that it was received in time to allow her to request further medication without missing any doses.

61. When Ms Grant reported having had an epileptic fit during the night, staff gave her an emergency alarm and made an appointment for her to see the outreach nurse that day. Ms Grant did so, and the nurse told her to make a GP appointment for a medication review.

62. We are satisfied that AP staff did everything that they could and should have done to ensure that Ms Grant was properly attending to her own health needs.

Ms Grant's relationships with other residents

63. Ms Grant's aunt asked whether she was being bullied or having difficulty with other residents at the AP. She had several confrontations with other residents. Staff said that these largely appeared to be clashes between residents with strong personalities. They took the conflicts seriously, and supported Ms Grant with advice. The AP manager told the investigator that there had been several disagreements, and she and other AP staff had managed them as tensions among the residents, rather than bullying.

Emergency response

64. Staff spoke to Ms Grant on the morning of 26 September. She said that she was fine and did not want staff to open her door, but a resettlement support officers rightly insisted that she had to see her, and did so. There were no indications of any problems at that point.

65. When another resident told the resettlement support officers that she had concerns about Ms Grant they went straight to her. When they could not get a response from her or get access to her, they immediately called for emergency services. It was unfortunate that staff could not get to Ms Grant, which delayed her receiving medical attention. However, we are satisfied there was nothing more that AP staff could have done in the circumstances.

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