Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Ms Deborah Clayton, a prisoner at HMP Askham Grange, on 19 August 2020

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 Deborah Clayton died on 19 August 2020, having been found hanging in her cell in HMP Askham Grange. Ms Clayton was 46 years old. I offer my condolences to Ms Clayton's family and friends.

In the weeks before she died, a prisoner-led trauma support group brought up difficult memories for Ms Clayton. Both officers and healthcare staff at Askham Grange offered support to Ms Clayton on several occasions, but she said she preferred to talk to other prisoners. When she subsequently had a family bereavement, staff appropriately opened Prison Service suicide and self-harm procedures (known as ACCT), even though Ms Clayton said that she did not feel them necessary.

I am satisfied that Ms Clayton was offered appropriate support and that staff could not reasonably have known she was at imminent risk of suicide at the time of her death.

I am, however, concerned that about the lack of structured support for women attending the trauma support group.

I am also concerned that there was a gap in sharing information between prison and healthcare staff, and that a nurse involved in the ACCT process had not had the appropriate training.

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 **April 2021**

Contents

Summary

Events

1. In 2016 Ms Deborah Clayton was sentenced to 10 years imprisonment. She had a history of substance misuse and had harmed herself in the past. In March 2020, she transferred to HMP Askham Grange, an open prison.

2. In June, Ms Clayton attended a prisoner-led support group (Healing Trauma) designed to give prisoners strategies for coping with past trauma. On 1 July, Ms Clayton told officers that this had stirred up difficult memories for her about historic abuse and she stopped going to the group. Ms Clayton said she did not want mental health support and also refused substance misuse support.

3. On 12 August, Ms Clayton was told that a former partner was seriously ill. Two days later, she learned that her step-sister had died. She reassured staff that she was fine and had no thoughts of suicide or self-harm.

4. On 16 August, staff started suicide and self-harm prevention procedures (known as ACCT) after Ms Clayton told an officer that she was having suicidal thoughts. Staff checked her at least once per hour. Ms Clayton said that she felt low but had no thoughts of harming herself. The ACCT was still in place at the time of Ms Clayton's death.

5. On 18 August, Ms Clayton saw the mental health nurse. She said that she was not sleeping well but was otherwise fine.

6. On the morning of 19 August, Ms Clayton told staff that she was 'okay'. Later that morning, staff found Ms Clayton in her room suspended by a ligature. They lowered her to the floor and tried to revive her, joined by medical staff, but were unsuccessful. Paramedics attended and, at 11.53am agreed that Ms Clayton had died.

Findings

Assessment of risk

7. We are satisfied that Ms Clayton was offered appropriate support when she said that the Healing Trauma group had stirred up some difficult memories, and that staff appropriately opened ACCT procedures after the death of her step-sister. Despite her assurances that she was not at risk of suicide or self-harm, staff left the protective measures in place.

8. We are satisfied that staff had no reason to consider that Ms Clayton was at imminent risk of harming herself at the time of her death.

9. We are concerned that prison officers did not tell healthcare staff that Ms Clayton's step-sister had died. The nurse who attended the ACCT review did not have access to prisoners' electronic records so was not fully aware of the background. We are also concerned that the nurse who attended the ACCT review had not received ACCT training.

Healing Trauma group

10. We are concerned that there was no structure in place to assess or support women attending the prisoner-led Healing Trauma group. This group had the potential to stir up painful memories and feelings, as it apparently did for Ms Clayton, and we would therefore have expected that it would have been more closely supervised.

Clinical care

11. The clinical reviewer was satisfied that Ms Clayton received healthcare equivalent to that which she could have expected in the community.

Recommendations

- The Governor and Head of Healthcare should ensure that important information that could affect a prisoner's risk is shared in line with PSI 64/2011.
- The Governor and Head of Healthcare should ensure that all staff in contact with prisoners have received appropriate ACCT training in line with PSI 64/2011.
- The Director for the Women's Estate should satisfy himself that the prisoner-led Healing Trauma group is appropriate to be delivered in prisons and, if it is, that groups are properly monitored and supported.

The Investigation Process

12. The investigator issued notices to staff and prisoners at HMP Askham Grange informing them of the investigation and asking anyone with information to contact him.

13. The investigator obtained copies of relevant extracts from Ms Clayton's prison and medical records.

14. The investigator interviewed five members of staff and one prisoner. NHS England commissioned a clinical reviewer to review Ms Clayton's clinical care at the prison. The investigator and clinical reviewer jointly interviewed healthcare staff.

15. We informed HM Coroner for North Yorkshire of the investigation. We have sent the coroner a copy of this report. At the time of writing, post-mortem and toxicology reports were not available.

16. One of the Ombudsman's family liaison officers contacted Ms Clayton's next of kin to explain the investigation and to ask if they had any matters they wanted the investigation to consider. They had no specific issues to raise.

Background Information

HMP Askham Grange

17. Askham Grange is an open prison and young offender institution (YOI), near York for women aged 18 and over. It holds around 128 women. Healthcare cover is provided between 7.30am to 5.30pm Monday to Friday, and 8,30am to 10.30am at weekends.

HM Inspectorate of Prisons

18. The most recent inspection of HMP Askham Grange was in April 2019. Inspectors reported a well-run, safe prison. Prisoners who needed support received it appropriately. Drugs and alcohol were not easily available. Levels of self-harm were low and, where necessary, ACCT procedures were good.

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 June 2019, the IMB reported that Askham Grange was a safe prison with supportive relationships between staff and prisoners. When ACCT procedures were opened, they were closely monitored, and support provided.

Previous deaths at HMP Askham Grange

20. Ms Clayton was the first prisoner to die at Askham Grange since 2006.

Assessment, Care in Custody and Teamwork (ACCT)

21. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Key Events

22. Ms Deborah Clayton was convicted of a violent offence and, on 6 December 2016, she was sentenced to 10 years imprisonment. She had a history of substance misuse, including heroin and crack cocaine, and had harmed herself in the past. She said that it was her first time in prison, but that she had been briefly sectioned under the Mental Health Act two years previously. Because it was her first time in prison, she was subject to ACCT monitoring, but this was closed the following day.

23. Ms Clayton engaged with substance misuse services. She took a number of offender courses. In early 2020 she successfully completed a period of release on temporary licence and on 25 March transferred to Askham Grange, an open prison

HMP Askham Grange

24. Ms Clayton settled well in Askham Grange. After an initial substance misuse assessment on 9 April, it was agreed that she did not need further support.

25. On 26 June, Ms Clayton attended a session of the Healing Trauma group, a peer-led support group run by prisoners. Notes are not kept of the meetings, but any important relevant information should be reflected on a prisoner's electronic record. There are no entries on Ms Clayton's electronic prison record that day.

26. On 1 July Ms Clayton was very upset. She said that she was having nightmares relating to historic abuse that she had suffered. On 2 July, a nurse assessed her. She denied any thoughts of harming herself. She had had Cognitive Behavioural Therapy in the past but had not really addressed the impact her childhood had had on her. The nurse referred Ms Clayton to the mental health team and substance misuse services.

27. A mental health nurse assessed her that same day. Ms Clayton said that she was having nightmares most nights. She used exercise to deal with her painful thoughts. She had attended the Healing Trauma group but was not sure that this was the right way for her to address her issues. She said she never felt like harming herself and did not feel that she had any mental health problems, but that she would like a follow-up appointment.

28. On 3 July, Ms Clayton told her offender supervisor that she would not return to the Healing Trauma group as it had stirred up past trauma. She said that her issues had subsided, and she felt well and did not want to work with the mental health nurse any longer.

29. On 9 July, the mental health nurse discussed Ms Clayton's attendance at the Healing Trauma group with the prison officers involved in it. They confirmed that Ms Clayton could go back to the group if she wanted to. In interview, the nurse said that she spoke to Ms Clayton about further support, perhaps with a psychologist. Ms Clayton said that she did not want to be referred for more support.

30. On 14 July, Ms Clayton saw a substance misuse counsellor. Ms Clayton said that going to prison had saved her life and that she had not used illicit drugs in three and a half years. She said she was worried about her daughters and had nightmares about her own historic abuse. She wanted to continue to work with support to prevent a relapse. The counsellor said she would provide counselling sessions, but Ms Clayton refused the next appointment scheduled for 23 July.

31. Ms Clayton did not attend a mental health appointment on 28 July or a rescheduled one on 4 August. She requested a further mental health appointment, which was planned for 18 August.

32. Ms Clayton began work in the prison laundry. On 11 August, she told her personal officer that she felt that she was 'in a good place'. She was concerned that she could not reach her daughter's social worker to arrange to see her but was looking forward to being able to have periods of release on temporary licence.

33. At lunchtime on 12 August, Ms Clayton told an officer that she was upset because her ex-partner was unwell and her older daughter (the ex-partner's daughter) was unhappy. Periods of temporary release had been suspended during the pandemic and Ms Clayton said she felt helpless.

34. On 14 August, Ms Clayton received news that her step-sister had died. She told an officer that she wanted to be left alone in her room. The officer reminded her that she could talk to someone if she needed to. The officer told wing staff what had happened.

35. On Saturday 15 August, Ms Clayton told an officer that she had decided not to attend her step-sister's funeral and she felt okay about it. The officer reminded her that support was available if she wanted it. He noted on her record that he did not have any concerns about her harming herself.

36. Later that day, the personal officer went to see Ms Clayton, who talked about her step-sister's death. She felt that she was becoming more positive and confident, and that attending the funeral would set her back. He discussed the support that was available, but Ms Clayton said she did not want it at that time.

16 August

37. On 16 August, Ms Clayton told an officer that she had thoughts of taking her own life. She said she felt that she did not fit in at Askham Grange and the Healing Trauma group had stirred up feelings for her. The officer started ACCT monitoring.

38. A Supervising Officer (SO) completed the ACCT immediate action plan. She arranged for Ms Clayton to move to a new room, nearer to a Listener (a prisoner trained by the Samaritans) who was also her friend. Staff were to check on her at least once per hour. Ms Clayton spoke to a Listener that afternoon.

39. Later that day, Ms Clayton told an ACCT Assessor that she felt low because her step-sister had died and her ex-partner and her father were both unwell. She said that she had no thoughts of harming herself and, although she was currently struggling, she was pleased with her new room and was still motivated to go to

work. She was having trouble sleeping because of nightmares from past trauma. She was still considering whether to apply to attend her step-sister's funeral.

40. That afternoon, Ms Clayton talked to another prisoner. The prisoner was concerned about Ms Clayton and asked a SO to speak to her again. The SO and an officer spent some time with Ms Clayton. The officer noted on Ms Clayton's ACCT document that Ms Clayton had settled into her new room but felt drained and wanted an early night. She was going to go to bed and watch television. When the prisoner saw her later, she thought Ms Clayton seemed better. When the officer checked her again later, Ms Clayton said that she felt better, and thanked her for her help.

41. The ACCT ongoing record shows that staff checked on Ms Clayton at least once an hour. At 1.55am Ms Clayton went to the staff office and said that the checks during the night were disturbing her. The night officer contacted the Night Orderly Officer, but it was agreed that hourly checks should continue.

17 August

42. When staff checked on Ms Clayton at 7.00am on 17 August, she was washed and dressed, and repeated that the overnight checks had disturbed her. When checked at 8.00am, Ms Clayton was in a good mood, and said that she felt better and was motivated. She spoke to a prisoner, who said that she appeared to be 'okay'.

43. That morning, a SO chaired an ACCT review. Ms Clayton attended, along with an offender supervisor and a nurse. The nurse did not know about Ms Clayton's recent bereavement before the review because officers had not told healthcare staff, who do not have access to prisoners' electronic records.

44. Ms Clayton said she did not need to be subject to ACCT monitoring because she had addressed her problems by talking about them. She said that she had not felt supported after her step-sister's death. She had decided not to attend the funeral. She had also decided not to pursue contact with her younger daughter, but to leave it to her to make contact. She said that she felt hands around her neck at night, relating to her historic abuse, which made her feel suicidal, but that she had no plans to self-harm or attempt suicide.

45. The SO reminded Ms Clayton of the support available. She was grateful that staff had moved her to a room closer to a Listener but said she did not like officers coming into her room at night to check her. She said that while she would attend her mental health appointment with the nurse the following day, she did not really want to engage with mental health services. She felt that she did not need ACCT monitoring, but that staff had imposed it on her, and that she was not being listened to. Ms Clayton then walked out of the meeting. Those present agreed that staff should continue to check on Ms Clayton at least twice each in the morning, afternoon and evening, and three times during the night.

46. Staff continued to check on Ms Clayton. At 1.50pm, an officer noted that she was in her room and was settled and relaxed. She said that she felt that her past was being used against her, and she wanted to move on. At 3.30pm she was in the television room, talking and laughing with other prisoners. At 6.00pm she

said that she felt like accepting help from the Safer Custody team, especially the SO, who she felt seemed genuinely interested in her wellbeing.

47. When staff checked on Ms Clayton at 7.00pm, the staff on duty said that they would do their best not to disturb her. Staff made the required checks during the night.

18 August

48. On the following morning, 18 August, Ms Clayton's ACCT ongoing record noted that she appeared to be in good spirits. She was concerned that staff had checked her more than three times during the night and officers agreed to look into this. A prisoner told us that Ms Clayton was tearful when she spoke to her and that she did her best to support her.

49. The nurse saw Ms Clayton for a mental health review. Ms Clayton apologised for walking out of the ACCT review the previous day but said that she felt uncomfortable being talked about. She said was not sleeping very well, and ACCT checks during the night were disturbing her, and she did not want to talk about the past but was otherwise fine.

50. When staff checked on Ms Clayton in the afternoon, she was in her room, then in the television room. At 6.00pm an officer spoke to Ms Clayton in her room. She said that she felt 'okay' but did not want to be under ACCT management because the overnight checks annoyed her. When the officer checked her again later, she said she was 'okay'.

51. Staff made the necessary ACCT checks during the night.

19 August

52. At 8.10am on the morning of 19 August, an officer went into Ms Clayton's room. She was watching television and said that she had already completed her cleaning job. A prisoner walked past the door and asked Ms Clayton if she was going into the association room for a chat. Ms Clayton said she would. The officer noted on the ACCT document that Ms Clayton seemed happy. The prisoner said in interview that Ms Clayton was on edge that morning and found it difficult to settle.

53. At approximately 10.20am, the officer went to check Ms Clayton, but she was not in her room. The officer made an announcement over the public address system asking Ms Clayton to go to the office. When Ms Clayton did not appear, the officer looked for her, but without success. She told an SO, the Orderly Officer, that she could not find Ms Clayton. He and others joined the search. The SO checked Ms Clayton's room and told the investigator that he was confident she was not there.

54. At 11.39am, the officer decided to check Ms Clayton's room again. She found Ms Clayton suspended from a heating pipe by a ligature made from a bed sheet.

55. The officer radioed a code blue emergency (meaning a prisoner is unconscious or having trouble breathing), which prompted the control room to automatically call an ambulance. She tried to cut the ligature but it was too thick so she lifted

Ms Clayton to relieve the pressure. Colleagues arrived and helped her, and a Custodial Manager (CM) undid the ligature and lowered Ms Clayton to the floor. He checked Ms Clayton for signs of life but was unable to find any.

56. The CM began to perform cardiopulmonary resuscitation (CPR). Healthcare staff arrived with medical equipment, including a defibrillator (a machine that monitors and, in some circumstances, restarts the heart). They continued attempts to resuscitate Ms Clayton until ambulance paramedics arrived and took over. At 11.53am, they said that Ms Clayton had died.

Contact with Ms Clayton's family

57. Police officers local to their home informed Ms Clayton's next of kin of what had happened. An officer was appointed as family liaison officer and liaised with the family. In line with Prison Service guidance, the prison offered a contribution to the costs of Ms Clayton's funeral.

Support for prisoners and staff

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

59. The prison posted notices informing other prisoners of Ms Clayton's death. Staff also spoke to prisoners, 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 Clayton's death.

Post-mortem report

60. Post-mortem reports showed that Ms Clayton died as a result of hanging.

Findings

Assessment of risk

61. Ms Clayton settled well at Askham Grange until the Healing Trauma group stirred up some difficult memories, compounded by family illness and bereavement.

62. We are satisfied that staff appropriately identified that Ms Clayton was at risk of suicide or self-harm after the death of her step-sister and started ACCT procedures.

63. Guidance on prisoners' risk is contained in Prison Service Instruction (PSI) 54/2011 *Management of prisoners at risk of harm to self, to others and from others.* The necessary actions were taken, and staff checked Ms Clayton as required. When she complained that checks during the night were disturbing her, staff tried not to disturb her.

64. During the first ACCT review, Ms Clayton made it clear that she did not want to be under ACCT management, but staff considered that her risk needed to be monitored, so did not close the ACCT.

65. When staff became aware that Ms Clayton was upset after attending the Healing Trauma group, they made sure she was offered support. When she heard about her step-sister's death, staff again made it clear to Ms Clayton that there were avenues of support available if she wanted to take them up. Her preferred means of coping was to talk to a Listener, so staff arranged for her to move rooms to be nearer to one. We are satisfied that Askham Grange provided Ms Clayton with opportunities for support when she might have needed it, but she did not always choose to use them.

66. When Ms Clayton heard of her step-sister's death, this information was not passed to the healthcare department. As a nurse could not access prisoners' electronic records, she did not know of Ms Clayton's bereavement when she went to the ACCT review. PSI 64/2011 says that information sharing is key to delivering safer custody. We make the following recommendation:

    The Governor and Head of Healthcare should ensure that important information that could affect a prisoner's risk is shared in line with PSI 64/2011.

67. The nurse said in interview that she had not received ACCT training. PSI 64/2011 says that all staff in contact with prisoners must be trained in ACCT procedures. We make the following recommendation:

    The Governor and Head of Healthcare should ensure that all staff in contact with prisoners have received appropriate ACCT training in line with PSI 64/2011.

Healing Trauma group

68. During her time in prison, Ms Clayton had not addressed the historic abuse she said that she had suffered until she attended the Healing Trauma group.

69. Healing Trauma is an intervention developed by a charity working with the criminal justice system and operates in a number of prisons in the female estate. It does not fall within the scope of interventions or instructions provided by the Prison Service. It is peer-led, though the meetings are overseen by prison officers who do not take part in the group work. Notes of meetings are not taken. There is no selection process for prisoners wishing to attend and no assessment of their vulnerability. There is no central policy for support or supervision of the prisoners involved in the groups.

70. The Deputy Head of Healthcare at Askham Grange told the investigator that she was not aware that the group had had adverse effects on other prisoners who had participated. However, she said there was no direct interface with mental health services and the healthcare team at Askham Grange were not informed when a prisoner joined the group.

71. Ms Clayton was offered support after she said attending the Healing Trauma group had stirred up difficult memories. However, we are concerned that officers only knew of her distress because she told them about it. We are surprised that there were no formal arrangements to support women attending the group.

72. The Healing Trauma group has been suspended at Askham Grange during the pandemic. Immediately prior to the suspension, it was agreed that at the prison's weekly Safety Intervention meeting that there would be discussion of prisoners who had been allocated to the group to ensure senior managers, including healthcare managers, would know who was participating.

73. The Prison Service's Lead Psychologist for the Women's Estate told us that they were in the process of developing a Trauma-Informed Strategy, which included strengthening the mechanisms for support for prisoners involved in Healing Trauma groups.

74. We make the following recommendation:

The Director for the Women's Estate should satisfy himself that the prisoner led Healing Trauma group is appropriate to be delivered in prisons and, if it is, that groups are properly monitored and supported.

Clinical care

75. The clinical reviewer was satisfied that Ms Clayton received healthcare equivalent to that which she could have expected in the community. She did not have any serious physical health problems. She appeared to have successfully addressed her substance misuse problems during her time in prison. The support offered to her by the mental health nurse was flexible and responsive. The clinical reviewer described the care given to Ms Clayton as of a good standard.

Substance misuse

76. In the absence of the results of post-mortem toxicology tests we cannot say whether illicit drugs played any part in Ms Clayton's death. She had a history of substance misuse. She went through detoxification in prison and worked with substance misuse services. She said that she had not used substances for

some years, and there is no evidence to suggest otherwise. Her friend told the investigator that she knew that Ms Clayton had used substances when they were in a different prison earlier in their sentences but was certain that she did not use them during her time in Askham Grange.

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