Prisons & Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Ms Angela Vickers, a prisoner at HMP Foston Hall, on 5 July 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*

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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 Angela Vickers was found unresponsive in her cell at HMP Foston Hall on 5 July 2019 having suffered severe blood loss from a small cut to her left shin. Staff attempted to resuscitate her but without success. She was 37 years old. I offer my condolences to Ms Vickers' family and friends.

Ms Vickers often self-harmed and was monitored frequently under Prison Service suicide and self-harm prevention procedures (known as ACCT) during her time in custody. Staff started her last period of monitoring after she made some superficial cuts to her arm and stopped monitoring a month before her death. I am satisfied that the decision to stop monitoring was a reasonable one.

It appears that stressful events were a trigger for Ms Vickers to self-harm but I have found no evidence to suggest that Ms Vickers intended to take her life on 5 July.

While I am satisfied that staff could not have reasonably anticipated that Ms Vickers was at particular risk, I consider that staff could have done more to address her repeated conflict with other prisoners.

I am also concerned that Ms Vickers had 12 different personal officers during her time at Foston Hall and that there were several occasions where the frequency of contact was not in line with policy. Staff might have understood Ms Vickers' issues better, and been able to address them, had there been a more consistent personal officer relationship.

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 **February 2020**

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Summary

Events

1. In December 2016, Ms Angela Vickers was remanded in custody charged with arson, and sent to HMP Foston Hall. She was later sentenced to 38 months in prison. This was her first time in prison.

2. On 18 May 2019, staff started suicide and self-harm prevention procedures (known as ACCT) after Ms Vickers made some superficial cuts to her arm. (Ms Vickers had a long history of self-harm through inflicting cuts and she had been supported under ACCT each time while in custody.) Monitoring ended on 5 June when Ms Vickers said that she was feeling settled and had no thoughts of self-harm or suicide.

3. Ms Vickers should have had a post-closure ACCT review on 12 June but there is no record of this.

4. On the morning of 5 July, Ms Vickers told an officer that she would not go to her education class that morning as she was being bullied by another prisoner. Ms Vickers' records show that she was often in conflict with other prisoners.

5. An officer went to make a routine check on Ms Vickers at 9.00am. The officer found Ms Vickers slumped on her chair with a large pool of blood nearby. The officer called a medical emergency code and nurses responded promptly and began cardiopulmonary resuscitation (CPR).

6. Paramedics arrived at 9.46am and assisted with CPR. Their efforts were unsuccessful and at 10.10am, the paramedics pronounced that Ms Vickers had died.

7. The post-mortem report gave Ms Vickers' cause of death as external haemorrhage (blood loss).

Findings

8. We are satisfied that the decision to stop supporting Ms Vickers under ACCT procedures on 5 June was a reasonable one.

9. A senior officer said that she saw Ms Vickers on 12 June for a post-closure ACCT review, but Foston Hall has been unable to provide us with the record of the review.

10. Ms Vickers was in frequent conflict with other prisoners. Prison staff dealt with such incidents through warnings and sanctions under the incentives and earned privileges (IEP) scheme. These measures had no effect on Ms Vickers' behaviour.

11. We have seen nothing to suggest that Ms Vickers intended to take her own life on 5 July, and it seems likely that her death was the accidental result of a relatively minor act of self-harm.

12. Foston Hall's Personal Officer Policy says that the prisoner's personal officer should make a minimum of one entry a month in the prisoner's record. There were several occasions where there was an interval of two or more months between personal officer entries in Ms Vickers' record. We also note that Ms Vickers had 12 different personal officers during her time at Foston Hall. We consider that this lack of consistency would have affected Ms Vickers' ability to develop a trusting relationship with her personal officer, as well as the officer's ability to develop a good knowledge of her issues and behaviour.

Recommendations

- The Governor should ensure that all ACCT documentation is properly secured and stored.
- The Governor should ensure that staff manage incidents of verbal and physical violence in line with the prison's Safety Strategy Policy, including that:
    - Staff should challenge all aspects of inappropriate behaviour and document this clearly.
    - Where inappropriate behaviour continues despite being consistently challenged, staff should make a Challenge, Support and Intervention Plan (CSIP) referral.
- The Governor should ensure that the personal officer scheme is effective in providing meaningful support to prisoners, particularly in building trusting relationships, and that contacts take place at a frequency in line with policy.

The Investigation Process

13. The investigator issued notices to staff and prisoners at HMP Foston Hall informing them of the investigation and asking anyone with relevant information to contact him. One prisoner responded.

14. The investigator obtained copies of relevant extracts from Ms Vickers' prison and medical records. He interviewed 12 members of staff and eight prisoners at Foston Hall on 1, 2, 14 and 15 August and subsequently spoke to two other staff by telephone.

15. NHS England commissioned an independent clinical reviewer to review Ms Vickers' clinical care at the prison. They jointly interviewed clinical staff.

16. We informed HM Coroner for Derbyshire of the investigation. The Coroner sent us the results of the post-mortem examinations. We have given the Coroner a copy of this report.

17. We contacted Ms Vickers' next of kin to explain the investigation process and to ask if she had any matters she wanted the investigation to consider. Ms Vickers' next of kin did not raise any issues.

Background Information

HMP Foston Hall

18. HMP Foston Hall is a closed women's prison serving courts in the Midlands. It holds up to 344 prisoners, including unconvicted and unsentenced women, young adult women under 21 years old and sentenced women including some serving life sentences.

19. Care UK provides healthcare services. There are daily GP sessions from Monday to Friday, with out of hours provision at other times. Three primary care nurses and a healthcare assistant are on duty during the day, reducing to one nurse and a healthcare assistant at night. Care UK provides mental health provision.

HM Inspectorate of Prisons

20. The most recent inspection of HMP Foston Hall was in February 2019 and the Chief Inspector's overall judgement was that it was a good report about a good prison. Inspectors found that most prisoners at Foston Hall felt safe and that violence was rare and incidents minor. Inspectors found that when incidents did occur, investigations and support for prisoners needed improvement. Inspectors found that paperwork on the application of the incentives and earned privileges (IEP) scheme was scant and provided little evidence of board decisions, patterns of behaviour, clear targets or case reviews.

21. Inspectors noted that incidents of self-harm were very high. They found that managers and staff displayed a good knowledge and understanding of the complexities of prolific self-harmers but analysis of data was not used to develop an effective whole prison approach to reduce the overall number of self-harm incidents. Inspectors noted that the quality of ACCT documents was variable with evidence of good practice as well as the need for improvement, such as a need for better tailored caremaps. Inspectors noted that 74% of prisoners reported having a mental health problem.

22. Inspectors found that the mental health team provided an improved range of low-level interventions while prisoners with a higher level of need were managed well and had access to psychiatric support.

Independent Monitoring Board

23. 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 30 November 2018, the IMB reported a slight increase in the number of prisoner complaints categorised as 'staff/prisoner concerns including bullying'. The IMB noted evidence of bullying of vulnerable prisoners although they also found that staff were proactive in dealing with incidents of bullying.

Previous deaths at HMP Foston Hall

24. Ms Vickers was the second prisoner to die at Foston Hall in the last two years. The previous death was from natural causes. There were no similarities between Ms Vickers' death and the previous one.

Assessment, Care in Custody and Teamwork

25. Assessment, Care in Custody and Teamwork (ACCT) is the care planning system the Prison Service uses for supporting and monitoring prisoners assessed as at risk of suicide and self-harm. The purpose of the ACCT process 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. Levels of supervision and interactions are set according to the perceived risk of harm. There should be regular multidisciplinary case reviews involving the prisoner. Checks made on prisoners should be at irregular intervals to prevent the prisoner anticipating when they will occur. Part of the ACCT process involves assessing immediate needs and drawing up a caremap to identify the prisoner's most urgent issues and how they will be met. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Incentives and Earned Privileges scheme

26. Each prison has an Incentives and Earned Privileges (IEP) scheme, which aims to encourage and reward responsible behaviour, encourage sentenced prisoners to engage in activities designed to reduce the risk of reoffending and to help create a disciplined and safer environment for prisoners and staff. Under the scheme, prisoners can earn additional privileges such as extra visits, more time out of cell, the ability to earn more money in prison jobs and to wear their own clothes. There are three levels: basic, standard and enhanced.

Key Events

27. On 13 December 2016, Ms Vickers was arrested and remanded in prison, charged with arson. She was sent to HMP Foston Hall. On 14 June 2017, Ms Vickers was convicted and sentenced to 38 months in prison.

28. On 13 July 2018, Ms Vickers was released on licence to a probation Approved Premises (AP). Ms Vickers was given notice to leave the AP due to her failure to engage properly with the regime and on 23 November, she was recalled to prison and returned to Foston Hall. On 1 March 2019, Ms Vickers was moved to HMP Styal but on 23 March, she was returned to Foston Hall and was moved to the first night centre (where newly arrived prisoners are initially held).

29. On 27 March, Ms Vickers saw a mental health nurse she had been seeing at Foston Hall since the previous November. Ms Vickers told her that she had asked to transfer to Styal, but had then asked to return as she was not getting as much support as she received at Foston Hall. She said she was pleased to be back. The mental health nurse noted that Ms Vickers had what appeared to be a deep cut to her left arm that was healing well. Ms Vickers said that she did not have any current thoughts of self-harm or suicide but she said that when she became frustrated she would respond by harming herself. She noted that Ms Vickers was not displaying any signs of mental disorder.

30. On 17 April, the mental health nurse saw Ms Vickers when she disclosed that she had been taking 'Mamba', a type of psychoactive substance– (PS). Ms Vickers asked her to treat this information in confidence as she was worried it might affect her prospects of parole. She told Ms Vickers that she would have to disclose the information and that staff would ensure she received support to stop her use of illicit substances. She noted that Ms Vickers was otherwise in a stable mood and denied having any thoughts of self-harm or suicide.

31. Following the consultation with the mental health nurse, a substance misuse counsellor, saw Ms Vickers on 25 April for an assessment of her substance misuse problem.

32. On 26 April, Ms Vickers told an officer that she had made cuts to her arm which she had done after other prisoners asked her to pay for some vaping devices that they had given her. (There is no evidence to indicate that Ms Vickers was in debt and at the time of her death her prison savings account was £31.59 in credit.) The officer started ACCT procedures. Ms Vickers had a lengthy history of deliberate self-harm, mostly through cutting, and had been supported through ACCT many previous times while in custody.

33. A nurse treated Ms Vickers' injuries, which she described as dry superficial cuts.

34. At the first ACCT case review on 28 April, Ms Vickers said that she had cut herself two days before simply because she was having a bad day and she regretted having done so. She said that she was enjoying her work as a wing cleaner but she questioned how much longer she would have to remain in the first night centre.

35. On 2 May, Ms Vickers saw the mental health nurse for a follow-up appointment. She noted that Ms Vickers was settled in mood and she said that she had stopped using illicit substances. She also noted that Ms Vickers was due to start 16 sessions with a psychologist for her sentence plan target in dealing with her offence of arson. Ms Vickers was moved to D Wing the same day.

36. On 5 May, Ms Vickers had a fight with another prisoner and officers intervened. Ms Vickers was punished by having 14 days loss of privileges and association and a 50 per cent reduction in earnings for 14 days.

37. On 13 May, staff stopped ACCT monitoring when Ms Vickers told a case review panel that she was happy on D Wing where she had a cleaning job. She also said that she was due to start working with a psychologist and expected to be released from prison in 16 weeks provided she had done the appropriate work with psychology.

38. The mental health nurse saw Ms Vickers on 15 May. She noted that Ms Vickers was in a pleasant mood. She said she was enjoying her job as a cleaner and she felt supported by staff. She noted that Ms Vickers agreed to the plan to discharge her from the mental health team and she was reminded how to access support again if needed.

39. On 18 May, staff restarted ACCT monitoring after Ms Vickers made superficial cuts to her arm. Ms Vickers declined to be treated by a nurse and she gave staff no proper explanation for her actions and she told them that she was fine. Ms Vickers was supported through hourly observations pending an ACCT review.

40. Staff tried to hold an ACCT review on 19 May, but Ms Vickers refused to attend. Observations were maintained at one an hour with one conversation each day.

41. On 21 May, an officer noted that Ms Vickers had barricaded her door and refused to attend work (she had also barricaded her door the previous evening). The officer told the investigator that he had known Ms Vickers for some time and said she was a person who could be volatile, and would often react inappropriately if something upset her, such as having an argument. He said that on 21 May he spent around five to ten minutes trying to persuade her to unblock her door and he then told her he would carry out some other duties and return a little later. He said that he returned to her room around 20 minutes later when she agreed to remove the barricade and she took a shower and tidied up her room.

42. Ms Vickers' next ACCT review was scheduled for 21 May, but operational difficulties meant that it had to be postponed until 22 May. A Supervising Officer (SO) chaired the ACCT review on 22 May which was also attended by Ms Vickers and a member of staff from psychology services. A nurse sent a written contribution based on Ms Vickers' last consultation with the mental health nurse. The SO noted that Ms Vickers was chatty throughout the review and he understood that she was working well with psychology. The SO noted that Ms Vickers had recently made some impulsive decisions, such as barricading her door, which resulted in her receiving punishments. He advised her that she needed to think about the consequences of her actions to try to avoid further punishment. Ms Vickers said that she was still having thoughts of self-harm and she was advised

about the things she could do as a distraction, such as doing some of her psychology work. The SO maintained observations at one an hour, but only during times of lock-up. Officers were also to continue having one conversation with her each day.

43. Ms Vickers made some superficial cuts to her arm that evening which did not require medical treatment. A SO arranged a further ACCT review, but Ms Vickers refused to attend.

44. On 26 May, a SO noted that Ms Vickers had received three negative reports in the previous week for blocking her observation panel, for refusing to go to work and for telling staff to “fuck off”. (Ms Vickers’ records contain many references to swearing at staff.) The SO noted that Ms Vickers would remain on the basic level of the incentives and earned privileges (IEP) scheme for a further seven days (she was already on the basic level when she served these additional days).

45. An SO chaired Ms Vickers’ next ACCT review on 29 May. Ms Vickers and an officer also attended. The SO noted that Ms Vickers was open and communicative, although she was a little bit grumpy as she had had to leave education early to attend the review. Ms Vickers said that she had no thoughts or intentions of self-harm or suicide. The SO made no changes to the frequency of observations and conversations. The SO told the investigator that Ms Vickers was very set in her ways, such as always being the first person to have use of the vacuum cleaner in the morning, and she could also be volatile. That said, the SO considered that the staff on D Wing had a good rapport with her.

46. The SO chaired Ms Vickers’ next ACCT review on 5 June. The review was also attended by Ms Vickers, a nurse and a Rabbi from the chaplaincy team. The SO noted that Ms Vickers was in good spirits and that she had no thoughts of self-harm or suicide. Ms Vickers said that she had settled on D Wing and was feeling better in herself. Ms Vickers also spoke about working with psychology and about leaving prison and moving to an Approved Premises. The panel decided to stop ACCT monitoring.

47. A nurse made a detailed note of the review in Ms Vickers’ medical record. He reflected most of the points made by the SO including the fact that Ms Vickers said that she had no thoughts of self-harm or suicide and was fully aware of the support she could receive from staff if needed.

48. Ms Vickers should have been seen on 12 June for a post-closure ACCT review but there is no record of the interview. The SO told the investigator that she had seen Ms Vickers that day for a review and she had completed the appropriate paperwork, which Ms Vickers signed. The SO did not know how the document went missing.

49. On 14 June, the SO noted that she spoke at length with Ms Vickers about the need for her to adhere to prison systems such as giving back the prison radio if she also had a television. She said that Ms Vickers had a habit of playing staff off against each other in the way systems were applied.

50. An officer told the investigator that he had been appointed as Ms Vickers’ personal officer towards the end of May and on 14 June he had a lengthy

conversation with her to talk about her sentence progression. He noted that she was halfway through her psychology sessions and he stressed to her how the course would help her parole application. (The officer was Ms Vickers' 12th personal officer at Foston Hall.)

51. A tutor who taught English at Foston Hall, made an entry in Ms Vickers' records about an incident with another student on 18 June when the prisoner accused Ms Vickers of laughing at her. The tutor told the investigator that the other prisoner started walking towards Ms Vickers, but Ms Vickers remained calm and remained seated and everything calmed down. She said that she gave Ms Vickers a positive entry for her behaviour that day, but there had been previous occasions when she had retaliated.

52. The tutor explained that her classroom comprised two sets of four tables and one set of six tables. She had ten students in each class and she acknowledged that the room was cramped. She said that students would work both alone and collaboratively. She said that her role included the need for students to acquire the skills needed for them to become employable on leaving prison, so they needed to learn about teamwork and communication. The tutor said that Ms Vickers always told her that she preferred to work alone so there were times she would work in a separate room alone with a mentor. She said that she would allow that if that was the only way to ensure Ms Vickers' 'attendance. She said that she was aware that Ms Vickers had made accusations that she was the target of inappropriate behaviour from other prisoners, but her view was that it was Ms Vickers who was the person who tended to cause problems with others.

53. On 19 June, another education worker made the following entry in Ms Vickers' records:

> "Angela has had a number of complaints made against her by prisoners who are finding her behaviour rude and antagonistic. A number of students are refusing to work in the class near her because of this ... she was heard to say, "if she hits me, I'll hit her back, I don't care", in reference to another student she has been winding up."

54. On 25 June, Ms Vickers left education following a dispute with another prisoner. An officer made the following entry in her records:

> "Angela returned … to the wing after a "heated discussion with [another student]. She decided this was the best option in order that there was not an altercation. Angela says when she gets a thought in her head, she will act on it …"

55. The tutor made the following entry in Ms Vickers' records which she believed related to an incident on 28 June:

> "Angela is behaving rudely and disrespectfully in class and she is not endearing herself to her peers. Instead of asking the peer mentor to move so she could sit down Angela made a scene and flounced out of the room. Angela came into the classroom room when everyone was concentrating and working quietly and she just burst in and started talking loudly over the heads of everyone … she was not at all happy when I tried to explain that it was

inappropriate and she also pushed past [another prisoner] knocking her chair as she was writing and did not apologise. Angela needs to realise how her behaviour needs to alter … and listen to my advice on how to behave suitably for the environment."

56. Ms Vickers did not go to education on 1 and 2 July as she had authorised sick leave for those days. There were no classes on 3 and 4 July.

57. Ms Vickers' offender supervisor told the investigator that Ms Vickers was initially a difficult person to work with as she was generally angry with the system and was angry that she had been recalled to custody after spending time in an Approved Premises. However, after her return from Styal to Foston Hall in March 2019, she started to engage with him and began to work towards her release. This was something she always wanted and she asked him about obtaining some of her property that had been held in a storage facility since the time of her arrest.

58. The SO told the investigator that she had spent a little bit of time chatting with Ms Vickers on the afternoon of 4 July. She said they were sitting together on one of the garden benches and just chatting on light-hearted matters. She said there had been no grounds to reopen an ACCT since the last ACCT was closed and Ms Vickers' death the following day was a shock to her.

59. The investigator spoke to eight prisoners who were friends and acquaintances of Ms Vickers at Foston Hall.

60. One prisoner told the investigator that she worked with the safer custody team by supporting socially isolated prisoners (those receiving few if any visits and having limited community contact). She said that Ms Vickers had clashes with other prisoners at times, including in education. She said that there was nothing unusual about this within the female prisoner estate, she said that prisoners often mocked others and that could lead to an exchange of comments and sometimes to a fight. She said that Ms Vickers was generally quite quick to react. She said that while Ms Vickers would cut herself, this was her way of coping with stress. She said that Ms Vickers was hopeful about her prospects of parole in a few months and hopeful of not returning to prison.

61. A second prisoner told the investigator that she and Ms Vickers were very close friends. She acknowledged that Ms Vickers was quite immature in her ways and that led to her having disagreements and fights with other prisoners. She said that sometimes Ms Vickers was the aggressor and sometimes she was the victim. She said that Ms Vickers was hopeful about her future.

62. A third prisoner, who was transgender, spoke about Ms Vickers in similar terms to the way the second prisoner spoke about her with regard to her interactions with other prisoners. He said that in the final weeks, Ms Vickers was anxious to avoid confrontations with other prisoners, and especially in education, as she did not want her chances of parole to be affected. The prisoner said that he was also a person who self-harmed and said that people generally resort to self-harm when emotions become too difficult to deal with. He said that when Ms Vickers was particularly upset she tended to inflict deeper cuts than usual. On the morning of her death, Ms Vickers came to his cell at about 8.20am to say hello to

his pet budgerigar and then returned to her cell. Ms Vickers was quieter than usual but he was not unduly concerned.

63. A fourth prisoner told the investigator that Ms Vickers was excited about the prospect of leaving prison in November 2019. However, she was concerned that she might get into trouble if she reacted inappropriately to another prisoner who had been intimidating her in education.

64. None of the prisoners heard Ms Vickers call out for help on the morning of her death, although none of them believed that she intended to take her life.

5 July 2019

65. None of the regular D Wing staff were on duty on 5 July. The two officers on duty that day told the investigator that they knew Ms Vickers by sight but had had no significant previous dealings with her.

66. One of the officers carried out a roll check on D Wing at 7.30am on 5 July and said that when he checked on Ms Vickers she was already out of bed.

67. The other officer told the investigator that she unlocked the rooms on D Wing that morning. At around 8.20am, Ms Vickers told her that she would not be going to her education class that morning as she was being bullied by another prisoner. The officer asked her if her allegation was being dealt with and she said that it was. The officer said that Ms Vickers appeared in a stable mood. The officer returned to the wing office and then spent time dealing with another prisoner. She then telephoned the education unit to discuss Ms Vickers' allegation and she was told that Ms Vickers was in fact the instigator of the difficult relationship with the other prisoner. The officer then made an entry in Ms Vickers' record that she had been given a negative entry under the IEP scheme. She had intended to speak to Ms Vickers about this, but did not have time to do so before her death.

68. At about 8.45am, one of the officers delivered post to the prisoners. He was aware that Ms Vickers had already refused to go to education but he asked her if she was absolutely certain that she would not go and she said she would not. The officer said that there were no indications that Ms Vickers was upset or distressed.

69. At about 9.00am, the same officer began to make standard daily security checks on the rooms on D Wing and he reached Ms Vickers' room at about 9.26am. The officer told the investigator that when he opened Ms Vickers' door he saw her slumped on her chair with her legs stretched out and he saw a large amount of blood on the floor next to her bed. The officer said that he immediately called an emergency code red (used to indicate a prisoner is suffering blood loss) and he waited outside the room for the nurses to arrive. The officer said that he could not see where Ms Vickers was bleeding, he said that he had never previously dealt with such a situation and he did not know what to do.

70. A nurse said that she and another nurse were in the healthcare unit adjacent to D Wing and that they reached Ms Vickers' room in around 30 seconds. She said that they had taken equipment to deal with prisoners with cuts but as soon as she saw Ms Vickers, she realised they also needed an oxygen cylinder and other

equipment. She returned to the healthcare unit to collect the additional equipment and she also asked for the doctor and an extra nurse to attend.

71. The other nurse said that while her colleague was collecting additional equipment she and an officer moved Ms Vickers onto the floor and she started giving chest compressions. She said that even at the outset of giving compressions she believed that Ms Vickers was probably dead, but she believed she should continue with resuscitation efforts pending the arrival of the doctor or ambulance paramedics. She said that when extra staff returned from healthcare she took turns with a prison GP in giving compressions.

72. When the first nurse returned to Ms Vickers' room she checked her with a defibrillator and she and her colleague gave oxygen.

73. Ambulance paramedics were called when the code red call was made and they arrived at Ms Vickers' cell at 9.46am. The paramedics assisted with efforts to resuscitate Ms Vickers. Efforts continued until 10.10am, when the paramedics declared that further efforts should stop as Ms Vickers was dead.

Contact with Ms Vickers' family

74. At 9.46am, one of Foston Hall's functional heads telephoned Ms Vickers' sister in Wolverhampton to inform her that her sister had harmed herself and was going to be taken to hospital in Derby. She advised Ms Vickers' next of kin that she should make her own way to the hospital. Ms Vickers' sister said that she was in work and as she worked in a care home she could not leave.

75. A few minutes later, the governing Governor telephoned Ms Vickers' sister to inform her that her sister was in a critical condition and she offered to meet her either at her place of work or at her home. Ms Vickers' sister agreed to meet at her home.

76. At 10.44am, the Governor and the functional head, drove to Ms Vickers' next of kin's home when they informed her that Ms Vickers had died.

77. Foston Hall contributed to the cost of Ms Vickers' funeral in line with national instructions.

Support for prisoners and staff

78. The Deputy Governor debriefed the staff who were closely involved in Ms Vickers' care and in the response when Ms Vickers was found. The staff care team also offered support.

79. Arrangements were made to personally inform all prisoners of Ms Vickers' death. Prisoners in the rooms near Ms Vickers' room were offered the chance to move to different rooms. Additional support was offered to Ms Vickers' close friends, and Listeners (prisoners trained in the role of Samaritans) were asked to walk the wings and to make themselves available. The prison posted notices informing other prisoners of Ms Vickers' 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 Vickers' death.

Post-mortem report

80. Ms Vickers' post-mortem report showed that she had a wound on her left shin that was 1cm long and which had penetrated an artery. Her cause of death was found to be external haemorrhage. Results of toxicology tests showed the presence of sertraline at a therapeutic level. Naproxen and dexamethasone were also detected but were considered unlikely to be significant.

Findings

Assessment of Ms Vickers' risk of suicide and self-harm

81. Ms Vickers was frequently supported through ACCT procedures and always in response to acts of self-harm through cutting. Her final ACCT was opened on 18 May and was closed on 5 June when Ms Vickers assured the review panel that she had no current thoughts of self-harm or suicide. The decision to close the ACCT that day seems a reasonable one and we are satisfied that nothing occurred after its closure that should have caused staff to believe that Ms Vickers was again at imminent risk of self-harm or suicide.

82. There is nothing to suggest that Ms Vickers intended to take her own life on 5 July and it seems likely that her death was the accidental result of a relatively minor act of self-harm.

Management of ACCT procedures

83. Following the closure of Ms Vickers' ACCT on 5 June, she should have been seen on 12 June for a post-closure ACCT review. An SO said that she met Ms Vickers that day and completed the appropriate paperwork. However, this document is missing from Ms Vickers' records. We make the following recommendation:

    The Governor should ensure that all ACCT documentation is properly secured and stored.

Violence reduction

84. Foston Hall's Safety Strategy Policy has a stated aim of ensuring that prisoners are protected from all aspects of harm whether physical, emotional or psychological. The policy goes on to say that in order to achieve its aim the prison has adopted a zero-tolerance approach to all violence, including verbal violence, as well as implied violence. In managing instances of violence Foston Hall uses the national Challenge, Support and Intervention Plan (CSIP). CSIP is a supportive, not a punitive measure, where a prisoner can be placed on report and monitored and supported for behaviour that can include persistent disruption of the regime as well as for behaviour that can be identified as harmful to others, for example bullying, aggression and hostility.

85. However, Foston Hall's Safety Strategy Policy also says that CSIP should only be used as a last resort where all other avenues have been exhausted. The policy states that wing staff must challenge and document poor behaviour on NOMIS (the prisoner's record) and a CSIP referral must only be used where the behaviour is sustained over a period of time despite being challenged.

86. Ms Vickers often found herself in conflict with other prisoners with her behaviour described at times as being rude and antagonistic. The evidence suggests that there were times when Ms Vickers instigated confrontations and times when other prisoners were the instigators. Ms Vickers refused to attend education on 5 July, telling an officer that she was being bullied by one of the other learners. Mr Vickers cut herself very shortly after this.

87. While Ms Vickers' conflicts with other prisoners did not generally escalate beyond the exchange of insulting words, this was a persistent feature, as was her use of inappropriate language towards staff. Although Ms Vickers was often punished through the IEP scheme, this had little or no impact on her behaviour and there was little evidence of staff challenging her behaviour in a more proactive or constructive way. We make the following recommendation:

The Governor should ensure that staff manage incidents of verbal and physical violence in line with the prison's Safety Strategy Policy, including that:

- **Staff should challenge all aspects of inappropriate behaviour and document this clearly.**
- **Where inappropriate behaviour continues despite being consistently challenged, staff should make a Challenge, Support and Intervention Plan (CSIP) referral.**

Personal officer contact

88. Foston Hall's Personal Officer Policy, published in April 2016, acknowledges that prisoners often enter prison with a variety of complex personal problems and individual needs, and can also lack pro-social behavioural skills. The policy's aim is to provide appropriate information, advice, guidance and encouragement to support and aid prisoners in addressing these areas. According to the policy, personal officers should make a quality case note entry in each of their allocated prisoners' records at least once a month.

89. There were four occasions where there was an interval of two or more months between personal officer entries in Ms Vickers' prison record and one occasion where there was an interval of seven weeks.

90. In addition, we note that Ms Vickers had 12 different personal officers during her time at Foston Hall (although it is possible that some of these staff were relief personal officers standing in for the regular personal officer). Ms Vickers was clearly a person with the complex personal problems and poor social skills that Foston Hall's Personal Officer Policy was designed to support. We consider that the frequent change of personal officer and periodic gaps between contacts, would have affected Ms Vickers' opportunity to build a rapport and trusting relationship with her allocated personal officer. It would also have affected the personal officer's ability to develop a good knowledge of her issues and behaviour. We make the following recommendation:

The Governor should ensure that the personal officer policy is effective in providing meaningful support to prisoners, particularly in building trusting relationships, and that contacts take place at a frequency in line with policy.

Clinical care

91. The clinical reviewer found that Ms Vickers' overall care was of a reasonable standard and equivalent to that which she could have expected to receive in the community. The clinical reviewer found that reception screening was delivered in line with national guidance and an appropriate referral was made to mental

health services. The clinical reviewer found that mental health services engaged well with Ms Vickers and gave her appropriate support.

92. The clinical reviewer noted that a clear rationale was given for Ms Vickers' discharge from mental health services, although he considered that it would have been prudent for the team to remain engaged with Ms Vickers while she was attending time-limited psychology sessions to assist in her sentence planning targets.

93. The clinical reviewer did not consider that Ms Vickers' death could have been predicted or prevented and he considered that staff responded well to the medical emergency.

94. The clinical reviewer made no recommendations.

Prisons & Probation Ombudsman

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