Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Ms Luisa Boultbee, a prisoner at HMP Foston Hall, on 15 July 2020

A report by the Prisons and Probation Ombudsman

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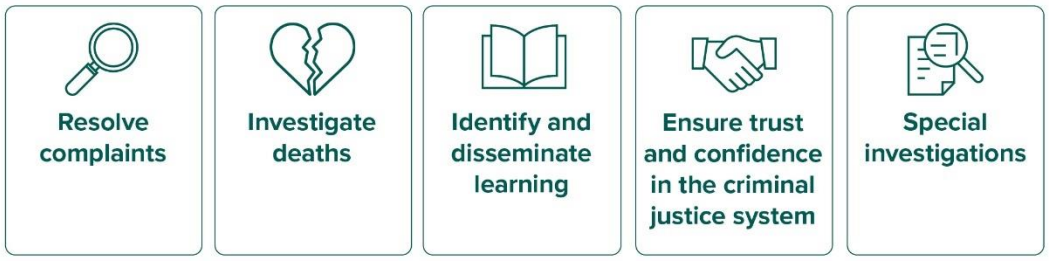
OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO



WHAT WE VALUE

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.

We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Ms Luisa Boultbee died suddenly and unexpectedly at HMP Foston Hall on 15 July 2020. She was 49 years old. I offer my condolences to Ms Boultbee's family and friends.

Ms Boultbee arrived at Foston Hall on 7 July. She had a history of poorly controlled epilepsy. The clinical reviewer was satisfied that the clinical care Ms Boultbee received at Foston Hall was equivalent to that she could have expected to receive in the community.

The investigation did, however, identify some concerns. Ms Boultbee's medications were not prescribed until the day after she arrived at Foston Hall, and a nurse did not physically examine Ms Boultbee when she complained of abdominal pain the night before she died. I am satisfied, however, that neither issue contributed to Ms Boultbee's death.

I am also concerned that Ms Boultbee was not checked every hour as she should have been during the night of 14/15 July. An officer recorded that they had checked on Ms Boultbee every hour, but CCTV footage shows that two of the checks were not carried out.

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

Elizabeth Moody
Deputy Prisons and Probation Ombudsman **February 2021**

Contents

Summary

Events

1. On 7 July 2020, Ms Luisa Boultbee was remanded in prison custody, charged with threatening and abusive words and behaviour and assaulting an emergency worker, and sent to HMP Foston Hall. Her Person Escort Record (PER) said she had epilepsy and was asthmatic.

2. When she arrived at Foston Hall, Ms Boultbee refused to engage with staff or answer questions. The reception nurse was concerned about Ms Boultbee's mental health and due to her behaviour and lack of medical history, started suicide and self-harm prevention procedures (known as ACCT). Ms Boultbee was also referred for a psychiatric assessment, but she died before this could take place.

3. At 10.30pm on 14 July, an officer called for a nurse because Ms Boultbee was complaining of abdominal pain. The nurse conducted a consultation through the cell door. She was satisfied that Ms Boultbee did not have a severe abdominal condition. The nurse returned at midnight and found Ms Boultbee was eating crisps. Ms Boultbee said she had bitten her tongue, so the nurse gave her paracetamol.

4. On 15 July, at around 6.43am, during a routine count of prisoners, Ms Boultbee was discovered unresponsive in her cell. There were signs that she had been dead for some time and so staff did not try to resuscitate her. At 7.13am, ambulance paramedics confirmed that Ms Boultbee had died.

Findings

5. The clinical reviewer found the overall care Ms Boultbee received was of a good standard and equivalent to that she could have expected to receive in the community. The clinical reviewer did, however, identify some concerns.

6. Ms Boultbee had several physical health conditions, including epilepsy. She was not prescribed all her community medications until the day after she arrived.

7. The nurse failed to physically examine Ms Boultbee on the evening of 14 July. This is poor practice, though we are satisfied the failing did not contribute to Ms Boultbee's death. During the investigation it became apparent that not physically examining prisoners during the night was a systemic issue and pre-dated the COVID-19 measures put in place to reduce transmission of the virus.

8. The night nurse did not record her contacts with Ms Boultbee in the ACCT document, observations by prison staff were not accurately recorded, and two observations were missed during the night Ms Boultbee died.

9. None of the staff who attended Ms Boultbee's room in response to the medical emergency used their body-worn video cameras (BWVCs) to record the incident.

Recommendations

- The Head of Healthcare should ensure that prisoners are prescribed essential medication on the day of arrival.
- The Governor and Head of Healthcare should ensure that nurses have access to prisoners at all times of the day and night, if there is a clinical need to assess them.
- The Governor and Head of Healthcare should ensure that staff manage prisoners at risk of suicide and self-harm in line with national guidelines, and in particular, staff should:
    - carry out observations at the agreed frequency and at unpredictable times;
    - ensure each prisoner can be seen clearly;
    - record details of all significant interactions on the ACCT document and record the exact timings of observations; and
    - act with urgency is a prisoner is unresponsive.
- The Governor and Head of Healthcare should ensure that all staff have adequate ACCT training and refresher training.
- The Governor should ensure that staff activate their BWVCs at the earliest opportunity during any reportable incident.

The Investigation Process

10. 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 her. No one responded.

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

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

13. The investigator interviewed five members of staff at Foston Hall with the clinical reviewer. She interviewed a further two members of prison staff and four prisoners. All the interviews were conducted by telephone because of the restrictions imposed in response to COVID-19.

14. We informed HM Coroner for Derbyshire of the investigation. The coroner gave us a copy of the post-mortem report. We have sent the coroner a copy of this report.

15. One of the Ombudsman's family liaison officers contacted Ms Boultbee's family to explain the investigation. Mr Boultbee's family wanted to know:

    - How Ms Boultbee's medication was managed.
    - Whether there were sufficient attempts to refer her to the mental health team.
    - What steps the mental health team took to assist Ms Boultbee to manage prison remand and the medication for her physical health.
    - Whether prison and healthcare staff were aware of Ms Boultbee's mental health history including her contact with police, ambulance services, and the hospital.
    - What procedures were in place to protect Ms Boultbee from COVID-19 and was she self-isolating as she was clinically vulnerable (which may have impacted upon her mental health).
    - What checks were completed throughout the night of 14/15 July 2020, were these checks of the quality expected and does CCTV confirm these checks were completed.

16. We have addressed these issues in our report.

17. Ms Boultbee's family received a copy of the initial report. They did not identify any factual inaccuracies within the report but, via their legal representative, did raise a number of issues which have been responded to separately.

18. The prison also received a copy of the report and did not identify any factual inaccuracies. An action plan for the recommendations is annexed to the report.

Background Information

HMP/YOI Foston Hall

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

20. Care UK provided primary and mental healthcare services (they changed their name to Practice Plus Group from 1 October 2020). There are daily GP sessions from Monday to Friday, with out of hours provision for other times. Three primary nurses and a healthcare assistant are on duty during the day, reducing to one nurse and healthcare assistant at night.

HM Inspectorate of Prisons

21. The most recent full inspection of Foston Hall was in February 2019. The Chief Inspector commented that it was a good inspection report about a good prison.

22. Inspectors found that health services had improved since the previous inspection. Healthcare staff saw all prisoners on arrival and a lead nurse in reception ensured that oversight of clinical activity was good. Inspectors reported that medicines management had improved significantly since the previous inspection.

23. Inspectors noted 74% of prisoners reported having a mental health problem. They found that the mental health team provided an improved range of low- level interventions, while prisoners with a high level of need were managed well and had access to psychiatric support.

24. HMIP carried out a short scrutiny visit to Foston Hall in May 2020 (along with two other women's prisons), to assess how well they had responded to the COVID-19 pandemic. Inspectors reported that isolating (known as 'cohorting') was done appropriately at Foston Hall. New arrivals were separated for 14 days in a designated 'reverse cohorting unit' (RCU). Reception procedures were operating well. However, there were weaknesses in identifying and prioritising support for some vulnerable prisoners, such as those new to custody and those who could not read the written material provided.

Independent Monitoring Board

25. 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 2019, the IMB reported that prisoners were treated fairly and with respect.

26. The Board noted there had been a considerable turnover of staff in healthcare since their last report, including the appointment and departure of a new healthcare manager. They also noted concerns about the timing and frequency of issuing medications at weekends and obtaining information about newly arrived prisoners' medications from community services, which led to delays of over 24 hours in reinstating medications.

Previous deaths at HMP Foston Hall

27. Ms Boultbee was the fourth prisoner to die at Foston Hall since July 2018. Of the previous deaths, two were self-inflicted and the cause of death in one unascertained. There were no similarities between the findings in our investigation into Ms Boultbee's death and our findings from the investigations into the previous deaths.

Assessment, Care in Custody and Teamwork

28. 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. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011*, Managing prisoners at risk to self, to others and from others (Safer Custody)*.

COVID-19 (coronavirus)

29. COVID-19 is an infectious, viral disease that affects the lungs and airways. On 24 March and in line with Government advice, HMPPS issued an instruction to all prisons to introduce social distancing and to implement a restricted regime and supported enforcement of social distancing of two metres for staff and prisoners, wherever possible.

30. On 31 March HMPPS, in consultation with Public Health England (PHE), issued an order to significantly reduce transfers between prisons. Other measures, known as 'compartmentalisation' were also announced. These measures were designed to be implemented at local level, depending on the needs of individual prisons, and included a reverse cohorting unit, where all newly arrived prisoners are located for 14 days to prevent the spread of COVID-19.

Key Events

31. On 6 July 2020, Ms Luisa Boultbee (also known as Louisa) was arrested for threatening and abusive words and behaviour and assaulting an emergency worker. Because of her bizarre behaviour Derbyshire Police referred Ms Boultbee to the Liaison and Diversion Team (who identify people in contact with the criminal justice system who have mental health, learning disability or substance misuse vulnerabilities). Ms Boultbee declined to be assessed and said that she did not need mental health input. (The next day a Consultant Psychiatrist at Derbyshire Healthcare NHS Foundation Trust, wrote to Ms Boultbee's GP to say she had been discharged from their services due to her lack of engagement following three Mental Health Act assessments and lack of engagement with the court diversion team.) A police doctor prescribed Ms Boultbee's epilepsy medication to her in police custody, but we do not know if she took it.

32. On 7 July, Ms Boultbee appeared at court and was remanded in prison custody. This was her first time in prison. Ms Boultbee arrived at HMP Foston Hall mid-afternoon. On her Person Escort Record (PER - a document that accompanies all prisoners when they move between police stations, courts and prisons and which sets out the risks they pose), court staff had recorded that Ms Boultbee had epilepsy and asthma.

33. An officer completed Ms Boultbee's cell sharing risk assessment (CSRA) and noted, 'Refused to engage… mental health issues.' A nurse noted on the CSRA, 'Bizarre behaviour. Refused to engage.' Ms Boultbee was assessed as increased risk and high CSRA, which meant she would be in a single cell.

34. The nurse recorded in Ms Boultbee's medical record that she had not been able to complete her initial health screen because she refused to answer any questions. Ms Boultbee's medical history was not available at the time as the community GP surgery had not yet released the records electronically to the prison. Ms Boultbee brought with her some out of date prescriptions for medication for epilepsy and mental illness.

35. A nurse was concerned about Ms Boultbee's mental health. She completed a Threshold Assessment Grid (TAG) screening document which is used in prison and the community to assess the severity and urgency of a mental health disorder. Ms Boultbee scored 12, indicating that she had an urgent need for mental health assessment with a significant risk to herself and others. The nurse started suicide and self-harm prevention measures (known as ACCT) at 3.15pm and noted, 'Non-engagement during reception screening. Bizarre presentation – first time in custody. Nil medical/mental health background info available (came in with MH [mental health] meds).'

36. A supervising officer completed the immediate action plan. He noted that Ms Boultbee did not answer any questions and refused to speak. He set observations at two an hour.

37. Ms Boultbee was moved to the first night centre, the reverse cohorting unit (RCU), in line with COVID-19 measures.

38. A pharmacist technician contacted Ms Boultbee's community pharmacy and confirmed her current medication. Later, Ms Boultbee had a telephone

consultation, due to COVID-19 restrictions, with a nurse. She told the nurse that she had been homeless on the streets and had been using alcohol, heroin and crack cocaine. This could not be verified as Ms Boultbee refused to provide a urine sample in reception. Ms Boultbee said that she had not been taking her epilepsy medication regularly. Because the nurse did not know if Ms Boultbee had used any illicit substances, she was not prescribed any medication. The nurse discussed his concerns with the duty night nurse and a care plan was put in place to manage any immediate risks during the night until Ms Boultbee was reviewed the next day.

39. An officer recorded that when Ms Boultbee arrived on the RCU she was allocated a personal officer (an officer who should get to know the prisoners they are responsible for, act as a first point of contact for any problems, help with resettlement issues and make regular entries in prisoners' records about their progress) and issued her PIN phone, but she refused to engage with staff.

40. All prisoners' telephone calls, except those that are legally privileged, are recorded, and prison staff listen to a random sample. Ms Boultbee made one telephone call to her parents at 6.44pm, which lasted nearly seven minutes. Ms Boultbee told them that she had been remanded, that she had not taken her medication and that she was scared.

41. Entries in the ACCT ongoing record note that Ms Boultbee was awake for most of her first night.

42. The next morning an officer tried to complete Ms Boultbee's ACCT assessment, but she refused to engage unless she had a legal representative. The officer described her behaviour as, 'Bizarre… requested writing paper to communicate with the Queen.'

43. A supervisor officer chaired the first ACCT review, attended by an officer and a nurse. They visited Ms Boultbee in her cell, but she did not engage and refused permission for the nurse to share any medical information. The nurse said she was concerned about Ms Boultbee's grandiose behaviour. Although she gestured at times in response to questions, Ms Boultbee became hostile and stated that her medication was overdue.

44. Staff at the case review assessed Ms Boultbee's risk of suicide and self-harm as low and reduced her observations to hourly.

45. Foston Hall received Ms Boultbee's community medical records which showed she had been diagnosed with epilepsy (since childhood) which was poorly controlled on medication; Attention Deficit Hyperactivity Disorder (ADHD); Asperger's Syndrome; mixed anxiety and depression; Chronic Obstructive Pulmonary Disease (COPD – lung disease); and asthma.

46. Later, a prison GP, prescribed all the medications prescribed by Ms Boultbee's community GP, without a consultation. A nurse attempted to complete Ms Boultbee's secondary healthscreen, but she refused to engage.

47. On 9 July, Ms Boultbee was discussed at the mental health team's morning meeting. A Nurse noted that her colleague had reported Ms Boultbee was grandiose and manic, and booked her in for the next available mental health triage assessment on 13 July. Ms Boultbee was given her medication twice daily by the

prison nurses. There is no record of her having had an epileptic seizure in the prison.

48. On 10 July, a supervisor officer chaired the second ACCT review, which was attended by an officer and Ms Boultbee. The supervisor officer attempted to obtain information from the mental health in-reach team but did not get a response. He noted Ms Boultbee said she needed a solicitor and then refused to engage with the review. The supervisor officer recorded that without the input from the mental health team, he was unable to complete the review, so he rescheduled the review for 13 July. Ms Boultbee's risk and level of observations remained unchanged.

49. On 13 July, a supervisor officer chaired Ms Boultbee's third ACCT review. An officer a nurse and a nurse from the mental health team attended. Ms Boultbee was adamant that she did not want to engage and would not cooperate with the mental health team. She was persuaded to come out of her room, but then said she did not need any help, would not cooperate and asked to return to her room. The supervisor officer recorded that her level of risk and observations would remain the same and that Ms Boultbee had a mental health assessment scheduled for the afternoon. He scheduled an ACCT review for 16 July.

50. Later, a nurse tried to complete Ms Boultbee's mental health assessment, but she refused to engage. The nurse noted that Ms Boultbee's room was messy, she appeared underweight and she was unkempt. The nurse described Ms Boultbee's behaviour as 'bizarre' and referred her back for discussion with the mental health team due to her non-engagement.

51. On 14 July, a multidisciplinary meeting discussed Ms Boultbee's lack of engagement and manic presentation. It was agreed that she should be assessed by a consultant psychiatrist. An appointment was made for 16 July.

52. Throughout the day, Ms Boultbee's behaviour continued to be difficult and she asked to be called 'Her Majesty'. She pressed her emergency cell bell several times and told staff she was getting married and wanted to walk in the gardens.

53. At 10.30pm, Ms Boultbee complained of abdominal pain and an officer requested the duty nurse. A nurse visited Ms Boultbee and conducted a consultation through the door. The nurse said Ms Boultbee did not appear to be in pain and had no other symptoms suggesting a severe abdominal condition. The nurse returned to see Ms Boultbee at midnight. She was eating crisps and complained that she had bitten her tongue. The nurse gave her two paracetamol tablets. She told the investigator at interview that Ms Boultbee appeared much more settled the second time she saw her.

15 July

54. Ms Boultbee should have been checked every hour during the night. Although the ACCT document recorded that Ms Boultbee was checked once an hour, CCTV shows that two of the checks did not happen. An officer signed the ACCT document at 6.25am and noted Ms Boultbee had 'slept all night'.

55. An officer arrived at the prison early for her shift. She received a handover from an officer who said that Ms Boultbee had used her emergency cell bell quite a lot earlier on in the night for different reasons, but there had been no other issues on the wing.

56. An officer started the early morning roll check at 6.39am and shortly afterwards arrived at Ms Boultbee's cell. The officer said she did not get a response from Ms Boultbee so used her radio to ask another officer to join her on the landing. The officer continued to count the rest of the landing and then went down to the wing office to find her colleagues.

57. The three officers returned to Ms Boultbee's cell. Officer Shepherd opened the door and said Ms Boultbee was lying on her bed, in an unusual position. One of the officers said she knew Ms Boultbee could be quite volatile and unpredictable, so shouted her name and used her key to brush the bottom of her foot, as she did not want to frighten her. He noticed Ms Boultbee was not breathing, checked to make sure there was no ligature and noticed there was some blood on her duvet. An officer radioed an emergency code blue at 6.43am (used to indicate a prisoner is unconscious or having breathing difficulties) and the control room called an ambulance immediately.

58. An officer said she and other officer moved Ms Boultbee with the intention of moving her to the floor in order to start cardiopulmonary resuscitation (CPR). However, the officer said there were clear signs Ms Boultbee was dead - she was stiff and her skin was mottled grey and purple - so she made the decision that it would be inappropriate to start CPR.

59. A nurse responded to the emergency code and arrived at Ms Boultbee's cell less than a minute later. The nurse agreed that it would have been undignified to have started CPR. The nurse recorded that Ms Boultbee was stiff, cold to touch and her blood had started to pool: all signs that someone has been dead for some time.

60. When paramedics arrived at Ms Boultbee's cell at 7.02am, they examined her and at 7.13am, confirmed that she had died.

Contact with Ms Boultbee's family

61. The prison appointed a prison manager, as the family liaison officer. Although under normal circumstances next of kin should be informed of a death in person by a FLO wherever possible, government advice at the time prohibited all but essential travel and required social distancing to prevent the spread of the COVID-19 virus. The family liaison officer therefore informed Ms Boultbee's daughter of her death by telephone. The prison provided ongoing support and contributed towards the costs of Ms Boultbee's funeral, which was held on 14 August, in line with national policy.

Support for prisoners and staff

62. The duty governor held a hot debrief with all staff involved in the emergency response. Most staff said they felt well supported and the Post-Incident Care Team spoke to everyone involved. Staff were offered further support by the chaplaincy and mental health team.

63. The prison posted notices informing other prisoners of Ms Boultbee's death and offering support. Staff reviewed all prisoners considered to be at risk of suicide and self-harm, in case they had been adversely affected by Ms Boultbee's death.

Post-mortem report

64. The post-mortem examination did not find any cause for the abdominal pain Ms Boultbee reported the night before she died and concluded that this did not contribute to her death. There was no evidence of natural disease, trauma or toxicological or biochemical abnormality that would explain Ms Boultbee's death, and the pathologist therefore concluded that Ms Boultbee died from sudden unexpected death in an epileptic patient (SUDEP). She commented that it is well recognised that patients with epilepsy have an increased risk of sudden death, particularly at night.

65. Toxicology results showed that Ms Boultbee had only traces of anti-epilepsy medication. The pathologist commented that this may have increased her risk, although SUDEP can occur even with full compliance with medication.

Findings

Clinical care

66. Prison Service Order (PSO) 3050, *Continuity of healthcare,* says all prisoners who arrive in prison custody should have an initial healthscreen while in reception, and if appropriate, be referred to the doctor to assess their physical and mental health needs, including any medication they may be prescribed.

67. The clinical reviewer concluded that overall Ms Boultbee's clinical care was of a good standard and equivalent to that which she could have expected to receive in the community.

Physical Healthcare

68. Ms Boultbee arrived at Foston Hall on the afternoon of 7 July. She arrived with some out of date prescriptions for epilepsy and mental illness and refused to engage with the nurse during her initial health screen. A pharmacy technician confirmed her medications a short while after she arrived, although these were not prescribed by the prison GP until the next day.

69. Ms Boultbee was prescribed medication for asthma and COPD, which continued in prison, and she was added to the prison's COVID-19 risk register as being at high risk from the virus due to her lung conditions. The post-mortem examination found that Ms Boultbee's lungs did not show any long-term effects of asthma or COPD and there was no evidence that COPD contributed to her death.

70. Ms Boultbee died suddenly and unexpectedly, but had epilepsy. There is evidence from the toxicology tests that Ms Boultbee was not taking her medication in full doses as prescribed, which put her at increased risk of having a seizure and therefore of death. Although her medication was dispensed to her from 8 July, she appears not to have taken it. No medication was found in her cell after she died, so we do not know if or how she disposed of it.

71. The clinical reviewer concluded that the lack of medication until the day after Ms Boultbee's arrival was regrettable, but it was unlikely to have contributed to her death. However, Ms Boultbee was clearly concerned about her medication from her conversation with her parents when she first arrived, and she mentioned it when staff attempted to review her ACCT. The delay may therefore have impacted on her level of stress and anxiety. We make the following recommendation:

    The Head of Healthcare should ensure that prisoners are prescribed essential medication on the day of arrival.

72. When Ms Boultbee complained of abdominal pain on the evening of 14 July, the nurse did not examine her because she did not assess there was a clinical need to enter her room. The nurse said that Ms Boultbee was erratic, difficult to engage and did not show any signs of physical discomfort. She said healthcare staff would typically only ask for a cell to be opened during the night if a medical emergency was radioed (code red or code blue) or there was a severe clinical need. An officer also said that it was common practice to only open a cell door at night if it was an emergency.

73. The Head of Healthcare said that she was 'dismayed' when she was told nurses do not examine prisoners in person at night unless it was an emergency. She said that although the Governor had reassured her there were enough prison staff for cells to be opened during the night, there was 'unquestionable reluctance from prison staff to open the doors at night'. She said practice was immediately changed, with the Governor's support, after Ms Boultbee's death, although healthcare staff said that the change in practice would cause conflict with prison staff as they would not want to open cell doors at night. The Head of Healthcare had advised them that they should document any request to open a door, and any refusals. The Head of Healthcare went on to say that she did not want to create conflict between healthcare and prison staff but 'with all the will in the world, you can't assess somebody through a viewing panel properly.'

74. Although immediate action was taken after Ms Boultbee died to ensure nurses are able to assess prisoners in person when there is a clinical need to do so, it would seem there remains a reluctance from prison and healthcare staff about the change. We, therefore, make the following recommendation:

The Governor and Head of Healthcare should ensure that nurses have access to prisoners at all times of the day and night if there is a clinical need to assess them.

Mental healthcare

75. When she arrived at Foston Hall, Ms Boultbee's presentation caused concern due to her refusal to answer questions or engage with the nurse and prison staff trying to assess her. The nurse correctly completed a TAG assessment form, referred Ms Boultbee to the prison's mental health team and opened an ACCT as she was concerned about the risk of suicide or self-harm.

76. Ms Boultbee was not prescribed any mental health medication while at Foston Hall as she had not been prescribed or recommended to have medication in the community. Ms Boultbee's mental health was discussed several times at multidisciplinary meetings. On 14 July, she was allocated the next available appointment with a psychiatrist on 16 July. Ms Boultbee had had her mental capacity assessed in the community shortly before her arrival at Foston Hall, but as she died before her psychiatric assessment, there was no time for this to be done in the prison.

77. Ms Boultbee was assessed by a qualified mental health nurse within 24 hours of arrival at Foston Hall, as well as seeing a mental health nurse during ACCT reviews and she was listed to see a psychiatrist at the first available appointment. The clinical reviewer concluded that the care she received was equivalent to that she could have expected to receive in the community.

Substance misuse care

78. Ms Boultbee refused to give a urine sample to be tested for drugs but later the same day claimed to have been using alcohol, heroin and crack cocaine on the streets before she was remanded to prison. There is no evidence in her community or prison medical records of a substance misuse problem and there were no signs of withdrawal.

ACCT observations/record keeping

79. Staff appropriately opened an ACCT to monitor and support Ms Boultbee. On the night Ms Boultbee died, she should have been checked every hour. The ACCT record completed by Officer Ashmore records that Ms Boultbee was checked on the hour between 9.00pm and 3.00am (although CCTV shows these checks were in fact completed at differing unpredictable times). Although it is good practice to vary the timing of ACCT checks, it is also important that the time the checks are made is accurately recorded.

80. In addition, CCTV shows that there was no check between 12.04am and 2.01am (one hour and 57 minutes) or between 2.22am and 4.03am (one hour and 41 minutes). An officer said she was certain she completed her checks and did not recall why they had been missed.

81. We do not know what time Ms Boultbee died and we cannot say if the missed checks would have resulted in her being discovered earlier.

82. CCTV shows at 6.00am, an officer checked Ms Boultbee's cell, paused and rechecked before moving on. She said that she could see Ms Boultbee on her bed, in a similar position to how she had slept the previous night and was convinced that she saw her leg move, so had no concerns.

83. Both officers said that the round Perspex observation panels in the cell doors, about the size of a tennis ball, are difficult to see through as they are often scratched or smeared with something which makes checks difficult and distorts the view. There are hatches to each cell, which are larger and allow a view into the cell without any barrier, but they had been secured shut with plastic tags due to the COVID-19 virus in order to minimise transmission.

84. It is important that staff are able to observe prisoners on an ACCT clearly. We cannot say whether Ms Boultbee might have been discovered earlier if staff had been able to see her properly when she was checked during the night.

85. We are also concerned that, although the duty nurse visited Ms Boultbee twice that night, she did not make any entries on the ACCT document. A nurse said although she was familiar with the ACCT process, she had not received any formal training and would not normally write in an ACCT as this would be done by prison officers.

86. An officer said that although she had completed ACCT training historically, she had not completed any refresher training and was unfamiliar with the revised ACCT document being piloted at Foston Hall, which was introduced on 18 February 2019. She said she would not have recorded in the summary section of the ACCT or in Ms Boultbee's prison record that the nurse had visited her as she did not consider the contact was significant.

87. We do not agree. We consider that any contact with a prisoner being monitored under ACCT may be significant and should be recorded.

88. We are also concerned that when the officer could not get a response from Ms Boultbee when she carried out the early morning roll check, she continued with the count and then went downstairs to fetch her colleagues. We recognise that she had radioed for assistance, but this did not produce an immediate response. As a result, there was a delay of a few minutes before staff entered Ms Boultbee's cell.

89. We consider that any failure to respond by a prisoner being monitored under ACCT should be regarded as potentially serious, especially if they cannot be seen clearly, and that staff should act quickly to obtain assistance. In this case it made no difference to the outcome for Ms Boultbee as she had been dead for some time before she was found. However, in other emergencies, a delay of a few minutes may make the difference between life and death.

90. We make the following recommendations:

The Governor and Head of Healthcare should ensure that staff manage prisoners at risk of suicide and self-harm in line with national guidelines, and in particular, staff should:

- **carry out observations at the agreed frequency and at unpredictable times;**
- **ensure each prisoner can be seen clearly;**
- **record details of all significant interactions on the ACCT document and record the exact timings of observations; and**
- **act with urgency is a prisoner is unresponsive.**

The Governor and Head of Healthcare should ensure that all staff have adequate ACCT training and refresher training.

Body-Worn Video Cameras

91. None of the officers present when Ms Boultbee was discovered used a body-worn video camera (BWVC). PSI 04/2017, *Body Worn Video Cameras*, states it is mandatory for staff to use BWVCs at any reportable incident (as set out in PSI 11/2012, *Management and Security of the Incident Reporting System*) and that staff should start recording at the earliest opportunity to maximise the material captured by the camera.

92. An officer said that she did not activate her camera as she was focused on assisting Ms Boultbee, although she also said that she did not think it was appropriate to film in such situations. While we understand the desire to protect prisoners' decency in such situations, the PSI gives clear instructions. Someone else not directly involved should have complied with the requirement to activate their camera. We therefore make the following recommendation:

The Governor should ensure that staff activate their BWVCs at the earliest opportunity during any reportable incident.

Inquest

93. The inquest into Ms Boultbee's death concluded in November 2023. Mr Boultbee's death was Sudden Unexpected Death in an Epileptic Patient (SUDEP). Not escalating her non-compliance with epilepsy medication contributed to her death and not seeking advice for medical management of her epilepsy after she bit her tongue contributed to her death.

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