Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Ms Yasmin Adams, a prisoner at HMP Foston Hall, on 13 November 2016

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.

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 Yasmin Adams died on 13 November 2016 in hospital after she was found hanged in her cell at HMP Foston Hall. She was 25 years old. I offer my condolences to Ms Adams' family and friends.

Ms Adams had a history of suicide attempts, frequently self-harmed, had mental health issues and substance misuse problems. She also often displayed challenging behaviour. This made the task for staff managing her immensely difficult. I note that individual staff worked hard to keep Ms Adams safe, but I am concerned about the lack of an integrated and strategic approach to Ms Adams' care at Foston Hall. Ms Adams' case reviews were not multidisciplinary and staff did not consider managing Ms Adams under enhanced case management, which would have included more senior and specialist staff in her case reviews. The investigation also found that healthcare services were fragmented, and in particular, the substance misuse and mental health teams do not provide an integrated service.

I am also concerned that there is no clear policy outlining the use of the D wing annex and prisoners are informally located there for a range of reasons, including segregation and cellular confinement without the associated safeguards. Finally, the investigation found that while staff called healthcare when Ms Adams was found on 12 November, they did not immediately call an emergency code.

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

Nigel Newcomen
Prisons and Probation Ombudsman **August 2017**

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Summary

Events

1. On 29 August 2016, Ms Yasmin Adams was sent to HMP Foston Hall after being sentenced to six months imprisonment for possession of a blade/point in a public place. She had a history of suicide attempts, self-harm, mental health problems and substance misuse.

2. A nurse in reception started suicide and self-harm prevention procedures (known as ACCT) after Ms Adams told her that she wanted to kill herself. A few days later, a GP prescribed an antidepressant for Ms Adams after checking her prescription in the community. Ms Adams was supported by a substance misuse worker for her alcohol misuse while at Foston Hall and was given information on harm reduction, pre-release relapse and risk management, and provided with mindfulness and relaxation techniques.

3. Ms Adams frequently self-harmed while in prison and made and used ligatures made from a variety of materials, most often in the evening and when she was locked in her cell. Ms Adams was managed under the ACCT process throughout her time at Foston Hall and had 64 case reviews. Staff assessed Ms Adams' risk as raised for most of the time she was at Foston Hall, and she was observed three to five times an hour. Ms Adams' case reviews were not multi-disciplinary, and her case managers did not consider involving her family in the ACCT process, or managing her under the enhanced case review process.

4. On 11 September, a nurse referred Ms Adams to the mental health team after Ms Adams told her she was hearing voices. A mental health nurse reviewed Ms Adams at regular appointments and referred her for an assessment with a trainee forensic psychiatrist, who prescribed antipsychotic medication and continued to monitor her mental state. A consultant forensic psychiatrist assessed Ms Adams and recommended that she be transferred to hospital under the Mental Health Act on her release because of her risk of suicide in the community. Her ACCT case managers and substance misuse worker were not aware that arrangements were being made to transfer Ms Adams to hospital.

5. Staff disciplined Ms Adams after she displayed challenging behaviour, including running away from staff, shouting and kicking her cell door and lighting fires in her cell. She sometimes had privileges withdrawn, but her ACCT case managers developed a behaviour management plan that allowed her access to a TV at night and time out of her cell on days she was well behaved. She was disciplined with cellular confinement for two periods while she was at Foston Hall and subject to this punishment when she died. Staff did not record any exceptional circumstances justifying the decision to segregate Ms Adams while she was being managed under the ACCT process. On one occasion a mental health nurse provided conflicting advice about segregating Ms Adams, but there was no explanation of how this advice was taken into consideration as part of the decision to segregate.

6. On the morning of 12 November, staff removed several ligatures that Ms Adams had tied around her neck. At 10.58am, a prison manager visited Ms Adams and spoke to her about why she had ligatured, gave advice on activities she could use to distract herself, and said he would come back and visit her that afternoon. At

2.25pm, two officers checked on Ms Adams as part of ACCT procedures and saw that she was taking a table and her TV into the bathroom. Ms Adams said she would hang herself with the TV cord. The officers removed the TV and table from Ms Adams' cell and told a prison manager what had happened.

7. An officer checked on Ms Adams at 3.10pm and noted that she was standing at her door. At 3.39pm, the officer returned to check on Ms Adams with the prison manager. They could not see Ms Adams in her cell, so went into the bathroom to check on her. The prison manager and the officer found Ms Adams hanging from the shower rail from a ligature made from clothing.

8. The officer cut the ligature while the prison manager held Ms Adams. They lowered her to the floor and called a code blue (indicating that a prisoner is unconscious or has problems breathing). Another officer arrived and helped to move Ms Adams into the middle of her cell and started cardiopulmonary resuscitation (CPR). Healthcare staff arrived and continued CPR and gave Ms Adams oxygen. At 4.07pm, paramedics arrived and continued trying to resuscitate Ms Adams. They found a faint pulse and at 4.37pm, Ms Adams was taken to hospital. Ms Adams remained in hospital on life support, but on 13 November at 1.45pm, her life support was turned off and she died.

Findings

9. The investigation found that Ms Adams was challenging to manage, but her care was not sufficiently holistic. ACCT case reviews were not multidisciplinary and enhanced case reviews were not considered for Ms Adams, despite her clear risk of self-harm and suicide, mental health problems and challenging behaviour. Staff also failed to consider involving Ms Adams' family in the ACCT process.

10. The investigation found that the D wing annex was used for both safety and punishment and there was no clear policy outlining its purpose and use and hence many of the safeguards surrounding segregation and cellular confinement were not applied. We consider that Ms Adams' challenging behaviour, which was often managed using the disciplinary process, had much to do with the distress of being locked alone in her cell. The investigation identified that staff should consider the risks of using punitive approaches to address manifestations of distress. The investigation also found that when Ms Adams was placed into cellular confinement, staff did not sufficiently consider healthcare reasons not to segregate, or document whether there were exceptional circumstances which justified segregation, as required under Prison Rules.

11. The investigation identified that there was no integrated working within healthcare, and particularly between mental health and substance misuse services. Foston Hall does not have a dual diagnosis policy and, while Ms Adams was receiving support from both mental health and substance misuse services, there was no information sharing between these services or evidence that an integrated service was provided.

12. The investigation also found that while staff called for healthcare when they found Ms Adams, there was a delay of three minutes in calling a code blue.

Recommendations

- The Governor and Head of Healthcare should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including:
  - holding multi-disciplinary ACCT reviews involving all staff who can contribute to the care of the prisoner at risk;
  - using the enhanced case review process when appropriate; and
  - involving the prisoner's family in the ACCT process, when appropriate, and record this in the ACCT plan.
- The Governor should ensure that staff consider the risks associated with using punitive approaches to managing self-harm or manifestations of distress.
- The Governor should ensure that there is a clear policy outlining the purpose and use of the D wing annex and that prisoners located there are subject to the safeguards contained in PSO 1700 and PSI 64/2011 as appropriate.
- The Governor and Head of Healthcare should ensure that staff manage prisoners held in segregation in line with national guidelines, including that:
  - there are exceptional circumstances for segregating a prisoner who is identified as at risk of suicide and self-harm, and that the reasons for segregating are clearly documented in the ACCT plan, including other options that were considered but discounted; and
  - staff consider healthcare advice indicating cellular confinement is not appropriate and document how they have taken this into account when deciding to segregate a prisoner.
- The Governor and Head of Healthcare should ensure prisoners with dual diagnosis receive appropriate integrated treatment.
- The Governor and Head of Healthcare should ensure that all prison and healthcare staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies as outlined in the local Medical Emergency Response Code Protocol so that staff efficiently communicate the nature of a medical emergency, and there is no delay in calling, directing or discharging ambulances.

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 her. No one responded.

14. The investigator visited Foston Hall on 23 November. She obtained copies of relevant extracts from Ms Adams' prison and medical records and interviewed one prisoner.

15. NHS England commissioned an independent clinical reviewer to review Ms Adams' clinical care at the prison.

16. The investigator and clinical reviewer interviewed 11 members of staff and four prisoners at Foston Hall on 4 and 5 January and 7 February. The investigator interviewed a further three members of staff and one former prisoner by phone.

17. We informed HM Coroner for Derby and South Derbyshire of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

18. One of the Ombudsman's family liaison officers contacted Ms Adams' mother to explain the investigation and to ask if she had any matters they wanted the investigation to consider. Ms Adams' mother said that she would like to know why the prison did not contact her after her daughter made serious attempts to self-harm, why it took the police two to three hours to notify her that Ms Adams had been taken to hospital and why it was the police and not the prison that notified her. Ms Adams' mother also wanted to know about the level and frequency her daughter was being observed and whether prison staff considered constant observation. Ms Adams' mother received a copy of the initial report. She did not raise any further issues, or comment on the factual accuracy of the report.

19. The initial report was shared with HM Prison and Probation Service (HMPPS) who provided comments and this report has been amended accordingly.

Background Information

HMP Foston Hall

20. 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, short and long term young adult women under 21 years old and sentenced women, including some serving life sentences. CARE UK provides primary 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 from 8.00pm to 7.15am. CARE UK provides mental health provision.

HM Inspectorate of Prisons

21. The most recent inspection of HMP Foston Hall was in June 2016. Inspectors reported that care for prisoners at risk of self-harm was generally sound and women identified as a risk to themselves or others or those with complex needs were identified and managed through an enhanced case review process. Inspectors noted that custodial managers developed care plans for women with complex needs. The number of women managed under the ACCT process was high and case managers generally knew the women well and were caring and supportive. Inspectors recommended that mental health service capacity reflect the particularly needy population and include offering prompt access to talking therapies and group work.

Independent Monitoring Board

22. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to November 2016, the IMB reported that prison managers prioritised safer custody and made efforts to improve the effectiveness of the ACCT process. The IMB also highlighted the high number of women on open ACCT documents, but reported a proactive approach to manage those subject to ACCT, including good action plans to manage and reduce the risk of self-harm.

Previous deaths at HMP Foston Hall

23. Ms Adams was the fifth of six women to die at Foston Hall since January 2015. Our investigations into the deaths of two women in July 2015 and September 2015, found that ACCT case reviews were not always multidisciplinary and, in the later investigation, that prison staff underestimated the woman's risk of suicide and self-harm.

Assessment, Care in Custody and Teamwork

24. 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.

25. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. There should be regular multi-disciplinary review meetings involving the prisoner. As part of the process, a caremap (plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the caremap have been completed.

26. 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.

27. Enhanced case management should be considered under the ACCT process where a prisoner's behaviour is so challenging and disruptive that they need additional case management so that their heightened or exceptional risk of harm to self, others and/or from others is managed within the normal custodial regime. The Enhanced Case Review Team will involve all relevant disciplines and include more specialists and a higher level of operational management than a typical ACCT Case Review Team.

Dual diagnosis

28. Prisoners with mental health problems and substance misuse issues are known as having 'dual diagnosis'. In January 2016, we published a Learning Lessons Bulletin about the mental health of prisoners. This bulletin highlighted that difficulties in coping with mental health problems can be made worse when a prisoner also has to cope with battling drug or alcohol misuse. The bulletin recommended that mental health and substance misuse services should work together to provide coordinated care to prisoners, including the use of agreed dual diagnosis tools to assess prisoner needs, and regular meetings to discuss and plan joint care.

Segregation and cellular confinement

29. Segregation units (sometimes known as care and separation units) are used to keep some prisoners apart from others. This can be because they feel vulnerable or under threat from other prisoners or if they behave in a way that prison staff think would put people in danger or cause problems for the rest of the prison. They also hold prisoners serving punishments of cellular confinement after disciplinary hearings. Segregation is authorised by a prison operational manager who has to be satisfied that the prisoner is fit for segregation after an assessment by a member of healthcare staff.

30. Segregation unit regimes are restricted and prisoners are usually permitted to leave their cells only to collect meals, make phone calls and have a daily period of exercise in the open air. PSO 1700 says that normal cells within the segregation

unit should be well lit and equipped to a similar standard to other locations within the prison.

31. As segregation is an extreme and isolating form of custody, prisoners at risk of suicide or self-harm should be placed there only as an exceptional measure on the authority of a senior manager. Where possible, segregation should not be used for prisoners at risk of self-harm and where a prisoner is on an open ACCT they must only be located in segregation units in exceptional circumstances. The reasons must be clearly documented in the ACCT plan and include other options that were considered but discounted.

Key Events

32. On 29 August 2016, Ms Yasmin Adams was transferred to HMP Foston Hall after being sentenced to six months imprisonment for possession of a blade/point in a public place. She had been released from Foston Hall a month earlier after serving a sentence for similar offences.

33. Ms Adams had a history of substance misuse, suicide attempts and self-harm and had been diagnosed with borderline personality disorder (a serious mental disorder marked by a pattern of ongoing instability in moods, behaviour, self-image and functioning) and attachment disorder (a temporary disorder caused by a stressful event).

34. A nurse assessed Ms Adams in reception. Ms Adams said that she had started taking 20mg of fluoxetine (an antidepressant) two or three days previously. Ms Adams told the nurse that she wanted to kill herself, so he started suicide and self-harm prevention procedures (known as ACCT).

35. On 30 August, a nurse assessed Ms Adams for her second reception screening. Ms Adams said that she had started self-harming in the early hours of that morning and still had thoughts of self-harm. There is no record that Ms Adams self-harmed that day.

36. Later that morning, an officer assessed Ms Adams under the ACCT process. Ms Adams told him that, after her grandmother died in April 2015, her life had 'spiralled out of control' and she started self-harming and made several suicide attempts. She said that she had never been in trouble before her grandmother's death, and that she would be better off with her. He noted the anniversary of Ms Adams' grandmother's death as a trigger in the ACCT document (a trigger is an event that might increase the risk of suicide or self-harm). He noted that Ms Adams had a boyfriend and a close relationship with her mother, her aunt, and one of her sisters.

37. After her assessment, the officer held the first ACCT case review with Ms Adams and another officer. The officers spoke to Ms Adams about bereavement counselling and chaplaincy agreed to provide her with support while she was at Foston Hall and then refer her to services in the community when she was released. They noted that Ms Adams was open to speaking to bereavement counselling services. The officer noted that chaplaincy would provide bereavement support as an action in the caremap (plan of care, support and intervention). The review team assessed Ms Adams' risk as raised and agreed that she would be observed four times an hour with one conversation a day.

38. Four days later, after a nurse had contacted Ms Adam's GP in the community to check her medication, a prison GP prescribed fluoxetine for Ms Adams.

Substance misuse treatment

39. On 2 September, a substance misuse worker assessed Ms Adams. Ms Adams told her that she smoked approximately £10 worth of cannabis a day and had drunk alcohol daily for the past four weeks. She also said that she had overdosed on paracetamol the day before she arrived at Foston Hall and she had a history of ligaturing and self-harm. The worker said that she did not think that Ms Adams was dependant on alcohol and did not observe any withdrawal symptoms.

40. The substance misuse worker said that her main concern about Ms Adams was her cannabis misuse because of the effect this could have on her psychological state and mood. She continued to support for Ms Adams' during her time at Foston Hall by providing information on harm reduction, pre-release relapse and risk management and provided mindfulness and relaxation techniques. She said that she was worried about Ms Adams' safety on release, so she referred her to a social worker to provide support and advice about the services available to her in the community.

Managing Ms Adams' risk of suicide and self-harm

41. Ms Adams had attempted suicide several times in the community and was a prolific self-harmer in prison, with at least 57 incidents recorded before she died where she made ligatures that prison staff had to remove from her neck. There were a further four incidents of self-harm recorded that did not involve ligatures, where Ms Adams cut herself using metal from her lighter, a staple, and on one occasion she burned her arm with a lit tampon.

42. Ms Adams ligatured most frequently in the evening and when she was locked in her cell but she was also found with ligatures at other times of the day. She used a variety of materials including socks, clothing, cleaning cloths, bed sheets and her kettle cable. While the material was most often tied loosely around her neck, at times it was tighter and more difficult to remove, leaving red marks on her neck. Prison staff said Ms Adams did not lose consciousness when she tied ligatures and she was never found suspended. Staff spoke to Ms Adams about the risks associated with her behaviour on a number of occasions, but Ms Adams often laughed or smirked after a ligature was removed. Healthcare staff examined Ms Adams after each ligature and on all occasions found that she was breathing and swallowing normally and that no treatment was required.

43. Ms Adams sometimes talked about suicide. When staff asked her about this, she did not have a plan and would usually become more positive and talk about her boyfriend and being released. Before ligaturing, staff said that Ms Adams would often press her cell bell or put a note under her door telling staff to stay away because she was going to kill herself. Staff said that Ms Adams did not really talk about why she self-harmed, but sometimes said that voices told her to do it.

44. Ms Adams' risk of self-harm was managed under ACCT procedures throughout the time she was at Foston Hall and staff held 64 case reviews. Ms Adams' ACCT case managers said that she would sometimes participate in the case review and be quite open and talkative, while at other times she would be quiet and it would be difficult to get information from her. Nursing staff attended 10 ACCT case reviews and mental health staff provided verbal input into two case reviews. There were several case reviews where only one officer was present at the review. Actions identified in the caremap included referring Ms Adams to substance misuse and mental health services, engaging in activities within the prison, speaking to staff about her feelings and staff checking why she was unable to call her mother. Staff did not consider managing Ms Adams under the enhanced case management process or involving Ms Adams' family in the ACCT process.

45. Throughout the time staff managed Ms Adams under ACCT procedures, her observations ranged between three and five an hour with either one or two conversations each day. Staff assessed her level of risk as either high or raised,

apart from a brief period where they assessed it as low on 30 October after it was noted that she had been settled for a few days. Staff assessed Ms Adams' risk as raised at the time of her death.

46. Staff disciplined Ms Adams several times at Foston Hall for kicking her door, refusing to return to her cell, running away from staff, or being in places where she was not allowed to go. Ms Adams was punished by being put on basic IEP level, where she remained for most of her time at Foston Hall (this scheme aims to encourage and reward responsible behaviour. There are four levels: entry, basic, standard and enhanced). Her punishments included limiting the amount she was allowed to spend at the canteen, limiting the amount she could earn, and limiting the amount of time she could spend in association.

47. Staff provided updates on Ms Adams at weekly multi-disciplinary Support and Intervention meetings. An officer explained that prisoners who had been managed under the ACCT process for more than four weeks were automatically referred to this meeting, which provided an opportunity for staff to share information to help the ACCT case manager to think of new ways of working with the prisoner.

48. On 19 October, minutes from the Support and Intervention meeting noted that two officers had developed a 'Care, Support and Behaviour Management Plan' for Ms Adams. One officer said that staff often used this type of plan with prisoners who were being managed under the ACCT process but also had behavioural issues. Under the behaviour management strategy, if Ms Adams was well-behaved during the day, she could leave her cell to assist the wing cleaners and would be allowed to use a TV in the evenings. Staff also provided her with distraction packs that contained puzzles and colouring books which Ms Adams enjoyed using. Other support mechanisms that staff provided for Ms Adams were noted in the plan, including ongoing mental health services, bereavement support from chaplaincy, and her use of the gym.

Mental health care

49. On 11 September, Ms Adams told a nurse that she had been hearing voices telling her to kill herself and was struggling to cope. The nurse noted that Ms Adams appeared distressed, covered her face and had been crying. She referred Ms Adams to mental health because she said she was hearing voices and her frequency of self-harm had increased. She returned to Ms Adams cell twice that night after staff removed ligatures from Ms Adams' neck. She noted that there were no obvious marks on Ms Adams' neck and that officers had removed items of clothing from her cell.

50. On 19 September, a mental health nurse assessed Ms Adams. Ms Adams said that she thought she would be better off dead or hurting herself in some way nearly every day. The nurse assessed Ms Adams using screening tools for anxiety and depression and noted that Ms Adams scored 21 on the Generalised Anxiety Disorder Assessment (GAD) and 22 on the Patient Health Questionnaire (PHQ-9), which indicated that she had severe anxiety and depression. She referred Ms Adams to the psychiatrist for an assessment.

51. The next day, a trainee forensic psychiatrist assessed Ms Adams. Ms Adams told him that she was struggling to cope with the loss of her grandmother and that her mood was low and she had been crying. Ms Adams said she had been hearing

voices constantly for three weeks, she struggled to sleep and the voices kept her awake. She said the voices often told her to kill or harm herself, and shouted when she would not listen to them. Ms Adams said that she had been cutting herself and ligaturing because of the voices.

52. The trainee forensic psychiatrist noted that there were no other psychotic symptoms and that Ms Adams had previously been diagnosed with borderline personality disorder. Ms Adams said that she had been taking fluoxetine for four weeks but it was not helping. He noted that Ms Adams had ongoing thoughts of suicide and self-harm but did not have a plan to take her own life. He told investigators that he did not feel he had enough information at the end of his assessment to make a diagnosis, so he arranged to see Ms Adams for another appointment in two weeks time. He noted that the primary mental health team would provide weekly support to monitor her mood, mental state, and the effect of her medication.

53. On 23 September, a nurse noted that staff had discussed Ms Adams at a multi-disciplinary meeting and that her team would arrange for a GP to review Ms Adams' medication and the trainee forensic psychiatrist would reassess her. She also noted that the mental health team would speak to wing officers about therapeutic ways to support and manage Ms Adams' mental health and provide weekly distraction packs. She recorded that the mental health team would refer Ms Adams for relaxation and art therapy groups, and they would consider referring her to community mental health services, depending on how she was close to her time of release.

54. Later that day, a GP reviewed Ms Adams' antidepressant medication. Ms Adams told her that she did not think she should be on antidepressants because she had felt worse since she started taking them. The GP told Ms Adams to take her fluoxetine on alternate days for 2 weeks and then stop. After the review, the GP told a nurse that she was weaning Ms Adams off antidepressants over the next two weeks, but would like her reviewed by the psychiatrist because she was presenting as quite complex. She also wanted the psychiatrist to review Ms Adams' medication because antidepressants had not worked in the past, and she was hearing voices. The nurse noted that she would speak to the mental health team and the trainee forensic psychiatrist about this.

55. On 4 October, the trainee forensic psychiatrist reviewed Ms Adams. Ms Adams told him that she was doing 'alright', that she had tried to kill herself the other day by tying a ligature, but that she got help from staff. Ms Adams said that she was hearing the voices all the time and that they were telling her to kill herself but she would not tell him the plan because the voices would 'go mad'. She said that nothing would stop them and they were 'inside her head'. He prescribed 10mg of olanzapine (an antipsychotic) and noted that she should continue to take the same dose of fluoxetine (rather than reduce her dose as suggested by the GP). He noted that he would review Ms Adams in four weeks and that she should continue with her weekly mental health appointments.

56. On 25 October, a nurse reviewed Ms Adams and noted that she continued to struggle with voices telling her to harm herself. Ms Adams said that this last happened two days ago when she tried to hang herself with a sock. She said that her work as a cleaner and the distractions packs helped her not to focus on her negative thinking. She was taking her medication every day. The nurse noted that she would assess Ms Adams again in two weeks.

57. On 27 October, a consultant forensic psychiatrist assessed Ms Adams. He noted that he could not make a formal diagnosis because Ms Adams did not engage in the assessment, but that she appeared to have features of emotionally unstable personality disorder, including a tendency to act unexpectedly, chronic feelings of emptiness, and recurrent threats and acts of self-harm. He also noted that Ms Adams appeared to meet the criteria for multisubstance misuse in the community. He recommended that Ms Adams be detained under the Mental Health Act in an inpatient unit specialising in personality disorders, when she was released from prison. He noted that he had contacted Stoke Clinical Commissioning Group to identify a bed for Ms Adams on release, and had also spoken to specialist commissioners at NHS England about the possibility of obtaining a bed in a locked rehabilitation centre. He reported that there was a risk of suicide for Ms Adams if she was not detained when she was released from prison, and that her risks would be managed in prison using the ACCT document, close supervision and supportive care.

58. Ms Adams' ACCT case managers told investigators that they did not know that the psychiatrist had assessed Ms Adams and recommended that she be detained under the Mental Health Act on her release. Ms Adams' substance misuse worker said that she often referred prisoners to mental health services but did not usually hear back about her referrals and did not know about Ms Adams' mental health care while she was at Foston Hall. The trainee forensic psychiatrist told investigators that he was not aware that Ms Adams was undergoing substance misuse treatment in prison.

D Wing annex and cellular confinement

59. The D wing annex at Foston Hall consists of two, gated, observation cells. It is part of the segregation unit and is separated from D wing by a locked door. Foston Hall does not have a policy that outlines how the D wing annex should be used, however, the Deputy Governor told investigators that it is used as a safer environment for women in crisis who are at high risk of serious self-harm or suicide. She said that another function of the annex is as a safer location for women whose behaviour would normally mean they are segregated because of their risk to others, but who are also vulnerable in terms of risk to themselves.

60. Ms Adams was located in the D wing annex at various times while she was at Foston Hall. Sometimes Ms Adams was taken to the D wing annex when her risk of self-harm increased so that she could be more closely observed. At other times Ms Adams was relocated to the D wing annex after she was punished and given cellular confinement, but could not be located in a cell on a normal wing because she was a risk to herself or others (cellular confinement is where a prisoner is kept on the wing, but is locked in their cell for most of the day and taken out to shower and exercise separately from other prisoners on the wing).

61. Ms Adams did not like being alone in her cell and would often press her cell bell, kick her door and shout when she was locked in her cell. She would also refuse to go into her cell or run away from officers when it was time to be locked up. Staff sometimes needed to return Ms Adams to her room using control and restraint procedures. Each time restraints were used, healthcare staff examined Ms Adams. As her behaviour did not improve, Ms Adams was disciplined using the adjudication process. She was punished by placing her on cellular confinement, which was served either in the D wing annex or in a normal cell on the wing.

62. On 18 October, after Ms Adams lit small fires in her cell, she was moved to the D wing annex overnight for safety reasons. On the morning of 29 October, Ms Adams would not return to her room. Staff locked the wing and used restraint procedures to take Ms Adams back to her cell. That afternoon, Ms Adams ran to the recycling unit on the exercise yard and tried to get on top of some metal containers. Ms Adams refused to get down and tried to run past an officer, so staff restrained her and took her to the D Wing annex. They noted in Ms Adams' prison record that her clothing had been removed but was later returned, and that she had been given a distraction pack. A nurse assessed Ms Adams and noted Ms Adams had a bruise on her hand and told her to put it under cold water. The next day, staff held an ACCT case review in the D wing annex and assessed Ms Adams' risk as unchanged (raised) and the frequency of observations remained at four an hour with one conversation.

63. On 31 October, Ms Adams was punished for refusing to return to her room and given seven days of cellular confinement, 14 days loss of association and 21 days of reduced spending at the canteen. A nurse assessed Ms Adams for the prison health screen and noted that there were no medical reasons preventing segregation. Staff did not note the exceptional circumstances for segregating Ms Adams on the prison health screen, or in her ACCT document, as required under prison segregation rules. There is no record about any other options that were considered to manage Ms Adams' behaviour.

64. An officer and a nurse reviewed Ms Adams under the ACCT process and noted that she was tearful and that she felt like ligaturing because she was in the D wing annex. Later that evening, staff reviewed Ms Adams under the ACCT process again after she tried to ligature using a sock. Ms Adams said that the voices had told her to do this. For both ACCT case reviews, staff assessed her level of risk as unchanged (raised) and continued to observe her four times an hour with two conversations a day.

65. On 1 November, the trainee forensic psychiatrist assessed Ms Adams with a nurse. Ms Adams told him that things had been 'alright', she was sleeping better, and that she continued to hear voices but did not listen to them anymore. She said that she had not had any suicidal thoughts since she moved to the D wing annex but had attempted to harm herself on Sunday because of the voices. He noted that Ms Adams seemed ambivalent about any active thoughts of suicide and said she had no current plans to harm herself. He noted that although Ms Adams was hearing voices during the review, she was able to ignore them and continue to focus and her thoughts of suicide appeared to have stabilised over the past few days. He recorded that there were to be no changes to Ms Adams' medication and that she came across as more settled and able to exert more control over the voices.

66. At 2.25pm, Ms Adams was moved from the D Wing annex to C wing. Two officers reviewed Ms Adams' risk under the ACCT process and noted that Ms Adams was pleased to have moved back to the wing but she was not sure if she would self-harm. Approximately 20 minutes later, Ms Adams started banging on her door. Staff noted in her ACCT document that the banging continued until she spoke to staff at 3.26pm. Later that afternoon, she threatened to climb out of the window and began screaming and kicking the bathroom door which staff had locked so they could observe her. Ms Adams threatened to hang herself in the bathroom, so staff

moved her back to the D wing annex. Two officers held an ACCT case review with Ms Adams. Her level of risk and frequency of observations remained unchanged.

67. On 3 November, a nurse reviewed Ms Adams in the D wing annex. She noted that Ms Adams was calmer, had no thoughts of self-harm, and no self-harm had been reported by officers in the past few days. She recorded that no other concerns had been raised and that she had explored coping strategies with Ms Adams. She noted that she would review Ms Adams in one week.

68. On 4 November, Ms Adams was moved back to C wing. A few hours later, Ms Adams rang her cell bell because she had made some superficial cuts to her arm. Staff took her to healthcare but there are no notes about any treatment in her medical records. Later that evening, Ms Adams refused to move out of her bathroom so staff could see her. Staff decided to move Ms Adams to a cell in the D wing annex, but Ms Adams refused to move and staff moved her using force. An officer reviewed Ms Adams under the ACCT process after she was moved, but nobody else attended the review, including Ms Adams.

69. The next day, staff moved Ms Adams back to C wing and held an ACCT case review, where an officer noted that she was keeping herself distracted with drawing and colouring, and watched TV at night as part of her behaviour management plan. He noted that Ms Adams had an IEP review and staff decided that she would remain on basic level because of her refusal to move to a safer environment the day before.

70. At 9.00am on 6 November, Ms Adams' period of cellular confinement ended. On 6, 8, 9 and 10 November, Ms Adams self-harmed by tying ligatures and making superficial scratches on her arm. On 8 November during her ACCT case review, Ms Adams said that she was upset after her mother had not contacted her after she wrote her a letter. She asked to have her PIN phone numbers checked so she could call her mother. Staff did not consider involving Ms Adams' mother in the ACCT process.

71. At 8.40am on 10 November, Ms Adams refused to return to her cell so staff moved her using control and restraint procedures. An officer told a prison manager about what had happened and a nurse examined Ms Adams and noted that she had no injuries.

72. At 8.50am, staff held an ACCT case review with Ms Adams where they assessed her risk as high and she remained on four observations an hour with one daily conversation. Ms Adams had a ligature removed by prison staff during the day and at 5.30pm, staff held another ACCT case review where her risk was assessed as raised and her observations remained unchanged. An officer asked Ms Adams why she had ligatured and she shrugged her shoulders. There is no note in Ms Adams' records explaining why staff decided to reduce Ms Adams' assessed level of risk at this case review.

73. At 7.00pm on 10 November, a nurse examined Ms Adams after she had tied a ligature. Ms Adams told him about the voices she was hearing. She said that she suffered from this illness as a child and thought she had 'outlived the problem' but the voices had become constant of late and she did not know how to cope with it. She said that she intended visiting her GP when she was released and talked about her release date. She said that she felt reassured and did not have any further

thoughts of suicide or self-harm. He noted that the mental health team would review Ms Adams.

74. On 11 November, a healthcare assistant assessed Ms Adams after officers had removed a ligature. She noted that there were red marks to the front of Ms Adams' neck and that no treatment was required. An acting supervising officer held an ACCT case review with another officer, and Ms Adams spoke to staff but hid her face for the majority of the review. The officer noted that they reminded Ms Adams about the support that was available and that she asked them for more distraction work. The review team assessed her risk as raised.

75. At 2.25pm, staff disciplined Ms Adams for refusing to move back to her cell and gave her five days cellular confinement. At 3.30pm, a nurse assessed Ms Adams for the prison health screen. She noted in the segregation paperwork that there were healthcare reasons not to segregate Ms Adams at the time, but also circled 'no' on a form asking if there were any clinical reasons not to segregate at this time. There is no note in Ms Adams' record explaining how this advice was considered and staff did not record any exceptional circumstances for Ms Adams' segregation on the prison health screen, or in the ACCT document as required by prison segregation rules.

76. At 3.45pm, an acting supervising officer and another officer held the second case review that day. Ms Adams said she was not bothered about her punishment but felt like self-harming. The officers encouraged her to focus on the positives and noted that she understood this, and would listen to music and use her distraction work. The review team assessed her risk as raised and her observations remained at four an hour. This was Ms Adams' last ACCT case review.

Events of 12 November

77. At 10.20am, an officer noted in the observation book that Ms Adams had hidden in her bathroom with a ligature around her neck. He and another officer tried to remove the ligature, but Ms Adams resisted and they had to hold her down to remove it. At 10.29am, both officers checked Ms Adams as part of ACCT procedures and found her in the bathroom with a ligature around her neck for the second time that day. One officer said that Ms Adams struggled when they tried to take the ligature off so they had to hold her arm to remove it.

78. At 10.58am, a prison manager asked Ms Adams why she had ligatured that morning and she said that she was bored. He asked what they could do to help and Ms Adams said she wanted her cell door left open. He said that he could not do this because she was on cellular confinement, but she had her TV and colouring books to distract her. He said that he would come back in the afternoon to speak to her again and get her out of her cell for a bit and go to his office. Ms Adams said that she would see him that afternoon and he left her cell.

79. At 11.15am, Ms Adams gave an officer a complaint form. Ms Adams wrote on the complaint that an officer kept banging her head against the wall when removing her ligature and she wanted something done about this.

80. At around 1.40pm, a prisoner came and spoke to Ms Adams through her cell door. Ms Adams told her that she had nothing to live for and 'nothing to come out to'. The prisoner said that this was not an unusual conversation to have with Ms Adams and

that she had spoken to her about this before. She told Ms Adams that she had herself to live for and said that by the end of the conversation, she thought she had convinced Ms Adams not to harm herself. She went to the gym around 2.30pm.

81. At 2.25pm, Ms Adams was sitting in her bathroom and would not come out, so two officers went into Ms Adams' cell. She told them they could not come in and took her table into the bathroom, and then tried to take her TV into the bathroom. Officer A said that she thought Ms Adams would use the table to barricade herself in her cell and Ms Adams said that she would use the TV cord to hang herself. Staff removed the table and TV from Ms Adams' cell. She said that while not unusual, this was new behaviour for Ms Adams so she told a manager about what had happened. Approximately 20 minutes later, Officer B noted that he had checked Ms Adams as part of the ACCT process and she was standing at her cell door and appeared okay.

82. At 2.55pm, both officers went to check on Ms Adams but she did not respond and they could not see her, so they went into her cell. Ms Adams was holding her breath and her face was red. Both officers checked Ms Adams' neck for a ligature, but there was none. Ms Adams told the officers that she did not want them in her cell.

83. At 3.10pm, Officer B checked Ms Adams and noted that she was standing at her cell door. At 3.39pm, a manager went into Ms Adams' cell to check on her with the officer, but could not see her. He went to the bathroom, and when he opened the door, he saw Ms Adams hanging from the shower rail with a ligature made from clothing. Ms Adams had her back towards him and he noticed that her feet were blue. He told the officer that Ms Adams was hanging and they needed to get her down, and called for healthcare assistance over the radio but did not call a code blue.

84. The manager held Ms Adams while the officer cut the ligature. He said Ms Adams was cold and her body was very limp. He lowered Ms Adams to the floor and the officer put her in the recovery position. The manager said that they needed to find out if she was breathing and noticed that the ligature was loose but still around her neck.

85. Officer A arrived at Ms Adams' cell followed by an acting governor. Officer A asked them if Ms Adams was breathing. They said they did not know. She removed the ligature from Ms Adams' neck, and then moved her into the centre of her cell and started CPR. At 3.42pm, the governor called a code blue and asked for healthcare and an ambulance. The control room log notes that an ambulance was called at 3.42pm, however, ambulance records note that they received a call from the prison requesting an ambulance at 3.45pm.

86. At 3.43pm, nursing staff arrived at Ms Adams' cell. They attached the defibrillator machine which advised no shock. One nurse took over CPR from Officer A and the other nurse managed Ms Adams' airways and gave her oxygen. They took turns and rotated performing CPR and managing Ms Adams' airways. Officer B was taken out of Ms Adams' cell by another member of staff and was supported by the Care Team.

87. At 4.07pm, paramedics arrived at Ms Adam's cell. They continued attempts to resuscitate Ms Adams and gave her two rounds of adrenaline. Paramedics were

able to detect a faint pulse. At approximately 4.37pm, Ms Adams was taken to hospital by ambulance.

88. At approximately 1.45pm on 13 November, Ms Adams died in hospital. Ms Adams' family were with her when she died.

89. After Ms Adams' death, two former prisoners who were at Foston Hall with Ms Adams contacted Ms Adams' mother and said that they were concerned about the way Ms Adams was treated in prison. The investigator interviewed one of the former prisoners who said that Ms Adams just needed someone to talk to and that staff did not provide her with enough support. She said that after staff moved Ms Adams to the D wing annex, she was 'covered in bruises' and that she often had bruises on her wrists and elbows because staff moved her using force. The clinical review noted that each incident of controlled movement was attended promptly by the healthcare staff for assessment, and in most cases no treatment was required. The post-mortem report noted there were no injuries to suggest that Ms Adams was restrained or assaulted prior to her death.

Contact with Ms Adams' family

90. After the paramedics left on 12 November, the deputy governor and family liaison officer (FLO) contacted the police and asked them to tell Ms Adams' family that she had been taken to hospital. The FLO decided to ask the police to speak to Ms Adams' family rather than visit herself because she thought this would be quicker. However, she said that the police took a little longer to notify Ms Adams' family because the address Ms Adams had provided to the prison was incorrect. At 9.45pm, she met Ms Adams' mother at the hospital.

91. At around 1.45pm on 13 November, Ms Adams' mother told the FLO, who was at the hospital, that Ms Adams had died. The FLO offered condolences and support. The prison contributed to the costs of Ms Adams' funeral, in line with national guidance.

Support for prisoners and staff

92. After Ms Adams' death, the acting 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.

93. The prison posted notices informing other prisoners of Ms Adams' 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 Adams' death.

Post-mortem report

94. The post-mortem report noted Ms Adams' cause of death as hypoxic brain injury after cardiac arrest due to hanging.

Findings

95. Ms Adams was a very challenging person to manage and support. While she self-harmed frequently, we are satisfied that staff recognised her risk of self-harm and set an appropriate level of observations. Constant supervision would not have been appropriate for Ms Adams as this should be used only at times of acute crisis and for the shortest time possible. While Ms Adams' pattern of self-harm fluctuated, it occurred regularly and continued throughout the time she was at Foston Hall.

96. Staff warned Ms Adams many times that her chosen method of self-harm was extremely dangerous, but she continued to ligature. Ms Adams spoke about wanting to die but staff said that when they asked her questions about this, it did not usually appear to be her intention and she would start talking about her plans for the future. No one we spoke to thought she wanted to die. It does not appear that the act of self-harm on 12 November that led to Ms Adams' death was any different from the numerous previous occasions when she had tied something around her neck. There is no evidence that Ms Adams intended to kill herself on 12 November and it seems that her death was the consequence of her very risky self-harming behaviour.

97. We consider that, given the nature and frequency of Ms Adams' self-harm, it would have been extremely difficult for prison staff to have prevented her death. However, the investigation identified some deficiencies in ACCT procedures, use of the D wing annex, her segregation and cellular confinement, dual diagnosis and emergency procedures, which we set out below.

ACCT procedures

98. Prison Service Instruction (PSI) 64/2011, which gives guidance on how to manage suicide and self-harm procedures, requires ACCT case reviews to be multidisciplinary where possible, involving staff from relevant departments and services. Ms Adams had 64 case reviews between August and November 2016. Few of these reviews were sufficiently multidisciplinary and several reviews had just one other member of staff present, which is poor practice. Even when multidisciplinary attendance is not possible, it is implicit that ACCT case reviews, which are based on teamwork, involve more than one member of staff.

99. PSI 64/2011 recommends that prisoners at risk of suicide and self-harm are managed under an enhanced case review process in a number of circumstances, including prisoners whose behaviour is so challenging and disruptive that they need additional case management so that their heightened or exceptional risk of harm to self, others and/or from others is managed within the normal custodial regime. Management by an enhanced review team is not mandatory, but it includes more specialists and a higher level of operational management. While individual teams were doing some good work to support Ms Adams, there was little evidence of integrated working. Her ACCT cases managers did not know that the mental health team were arranging for Ms Adams to be sectioned under the Mental Health Act on her release, and the mental health and substance misuse teams did not provide an integrated service as outlined in the prison's dual diagnosis policy. With Ms Adams' behaviour, mental health problems, and frequent ligaturing, it would have been appropriate to consider an enhanced case review approach. A more high-level

approach from an enhanced case review team might have resulted in more regular attendance by mental health staff at reviews and a more coherent approach to managing Ms Adams' behaviour.

100. In March 2017, we published a Learning Lessons Bulletin about 'Self-inflicted deaths among Female Prisoners', where we found a clear theme of poor joint working between mental health and custodial staff, or weak integration of mental health care into the prison. Poor joint working involved limited information sharing, including limited input of mental health care professionals into ACCT reviews, or insufficient information on the woman's healthcare being incorporated into the ACCT document. We recommended that prisons should use enhanced care management to bring greater senior engagement, oversight, and responsibility for keeping the most complex and challenging female prisoners safe.

101. PSI 64/2011 says that prisoners who pose a risk of harm to themselves must be encouraged to communicate with their families, and that consideration must be given to inviting the prisoner's family to ACCT case reviews where this is thought to be beneficial. Contact with family can provide an important source of support to a prisoner in crisis and staff should facilitate this wherever possible and appropriate. Ms Adams' mother told investigators that she would have liked to have been involved in her daughter's care. In the week leading up to her death, Ms Adams told staff that she was upset that she had not spoken to her mother. While staff may have had reasons for deciding not to involve Ms Adams' family in the ACCT process, there was no evidence that her case managers considered inviting her family to case reviews, or otherwise involving them in the process.

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

- **holding multi-disciplinary ACCT reviews involving all staff who can contribute to the care of a prisoner at risk;**
- **using the enhanced case review process when appropriate; and**
- **involving the prisoner's family in the ACCT process when appropriate, and record this in the ACCT plan.**

D Wing annex

102. The D wing annex at Foston Hall is part of the segregation unit and used as a safer environment for prisoners at risk of self-harm, or as a location for prisoners who would be segregated but are vulnerable because of their risk to self. Earlier in her sentence, Ms Adams was moved to the D wing annex because she required a safer environment, but later she was moved there because she was under cellular confinement and her behaviour meant she could not be located in a normal cell on the wing. From 30 October until 6 November, and from 11 November until the time of her death, Ms Adams was often moved between the D wing annex and cellular confinement on C wing. While we recognise that Ms Adams' self-harm reduced while she was in the D wing annex, we are concerned that there is no clear policy governing the use of this location.

103. Some staff told investigators that the D wing annex was not seen as being part of the segregation unit. However, when Ms Adams was located there, it was sometimes noted in her ACCT document that she was in the segregation unit. Foston Hall does not have a policy outlining the purpose of the D wing annex and circumstances under which prisoners will be moved there for safety or punishment.

104. Prison Service Order (PSO) 1700 that details the procedures to follow when segregating prisoners and prisoners who are located in the D wing annex under cellular confinement are subject to the Prison Service Rules on segregation. PSI 64/2011 provides that gated cells must only be used when a prisoner requires constant supervision in order to receive concentrated attention designed to reduce their risk of suicide or fatal self-harm. Constant supervision can only be authorised by the Daily Operational Manager or the Senior Clinical Manager after consultation with each other and the decision documented in the ACCT Plan. If a prisoner is located in the D wing annex because they need to be in an observation cell for safety reasons, the safeguards for constant supervision in PSI 64/2011 must be provided. Without a clear policy outlining the purpose and use of the D wing annex, there is a risk that prisoners that are segregated in this location or moved for safety reasons will not be subject to the safeguards and protections for prisoners provided under PSO 1700 and PSI 64/2011. We make the following recommendation:

The Governor should ensure that there is a clear policy outlining the purpose and use of the D wing annex and that prisoners located there are subject to the safeguards contained in PSO 1700 and PSI 64/2011 as appropriate.

Use of punitive measures to manage Ms Adams' behaviour

105. In our Learning Lessons Bulletin about self-inflicted deaths of female prisoners, we identified that staff had inappropriately used punitive approaches, such as the adjudication process and the IEP scheme, to try to address instances of self-harm or manifestations of distress. Ms Adams ran away from staff when it was time for her to be locked up, shouted and kicked her door, repeatedly pressed her cell bell and lit fires in her cell. Staff often used control and restraint procedures to relocate Ms Adams, and her behaviour was regularly addressed by placing and maintaining her on the basic level of the IEP scheme and through adjudications which resulted in her punishment and being placed in cellular confinement. This approach was not effective in managing Ms Adams' behaviour, which we consider was in part a consequence of her distress at being alone in her cell. Their impact may, indeed, have been counter-productive.

106. We acknowledge that Ms Adams' behaviour was challenging to manage and that staff tried to identify alternative approaches through considering her at the Support and Interventions meeting. However, rather than using punitive measures to manage Ms Adams' behaviour, we consider that staff could and should have explored alternatives that addressed the underlying causes of Ms Adams' poor behaviour. When Ms Adams was located in the D wing annex and had more contact with staff, her behaviour improved and her level of self-harm reduced. Similarly, prisoners said that Ms Adams calmed down when she had someone to talk to. Involving her family and more senior staff and specialists through the enhanced case review process would have provided a more holistic approach to her management and may have identified ways of engaging Ms Adams and

addressing the underlying causes of her behaviour and self-harm. We make the following recommendation:

The Governor should ensure that staff consider the risks associated with using punitive approaches to managing self-harm or manifestations of distress.

107. As segregation is an extreme and isolating form of custody, prisoners at risk of suicide or self-harm should be placed there only as an exceptional measure on the authority of a senior manager. PSO 1700 and PSI 64/2011 both advise against the use of segregation for prisoners at risk of self-harm where possible and require that prisoners on open ACCTs must only be located in segregation units in exceptional circumstances, and the reasons must be clearly documented in the ACCT plan and include other options that were considered but discounted. There was no record of the exceptional circumstances for segregating Ms Adams, or other options that were considered to manage her behaviour.

108. PSO 1700 requires that a doctor or registered nurse must complete the Initial Segregation Safety Screen for prisoners who may be given a period of cellular confinement in order to advise the adjudicator if there are health factors that would indicate that cellular confinement would be unsuitable or unsafe. The adjudicator must take the doctor or nurses' advice that cellular confinement is inappropriate into account.

109. On 11 November, a nurse assessed Ms Adams and noted that there were healthcare reasons not to segregate Ms Adams, but also circled 'no' on a form asking if there were any clinical reasons not to segregate at this time. However, in authorising Ms Adams' cellular confinement, prison staff did not record exceptional reasons to segregate her as a prisoner being managed under ACCT procedures, that the nurse's recommendation in deciding to segregate Ms Adams was taken into account, or what other options had been considered. These reasons were also not recorded in the ACCT document or on Ms Adams' health screen, as Prison Service instructions require. Ms Adams' safety might have been given as an exceptional reason to segregate her, but this was not noted as a reason in her prison record. We make the following recommendations:

The Governor and Head of Healthcare should ensure that staff manage prisoners held in segregation in line with national guidelines, including that:

- **there are exceptional circumstances for segregating a prisoner who is identified as at risk of suicide and self-harm, and that the reasons for segregating are clearly documented in the ACCT plan, including other options that were considered but discounted; and**
- **staff consider healthcare advice indicating cellular confinement is not appropriate and document how they have taken this into account when deciding to segregate a prisoner.**

Dual diagnosis

110. The PPO published a learning lessons bulletin on 'Prisoner Mental Health' in January 2016. In this bulletin we identified that difficulties in coping with mental health problems can be made worse when a prisoner also has to cope with

difficulties of battling substance dependence. We recommended that mental health and substance misuse services should work together to provide a coordinated approach to prisoner care which should involve the use of agreed dual diagnosis tools to assess prisoner needs and regular meetings to discuss and plan joint care.

111. Foston Hall does not have a dual diagnosis policy. The trainee forensic psychiatrist and a nurse told investigators that they were not aware of any support the substance misuse team had provided to Ms Adams and a substance misuse worker said that she had not been informed about the care being provided by the mental health team. The nurse said that she would usually become aware that a prisoner under her care is also receiving support from the substance misuse team if the prisoner tells her or she referred them for services. The substance misuse worker said that when she refers a prisoner to the mental health team, she is not always told the outcome.

112. The clinical review report noted that there was no evidence of integrated working with the wider healthcare team, in particularly the mental health team. The report recommended that the healthcare team review how individual complex case discussions are planned to promote an integrated approach to case management, with particular reference to the joint working between mental health and substance misuse.

113. Mental health and substance misuse services should work together to provide a coordinated approach to prisoner care which should involve the use of agreed dual diagnosis tools to assess prisoner needs and regular meetings to discuss and plan join care. We make the following recommendation:

The Governor and Head of Healthcare should ensure prisoners with dual diagnosis receive appropriate integrated treatment.

Emergency response

114. PSI 03/2013 on Medical Emergency Response Codes requires staff to use a code blue or equivalent code in a medical emergency and for the control room to call an ambulance immediately an emergency code is used. The PSI is clear that prisons should not wait for healthcare staff or a duty manager to decide whether an ambulance is needed and that an ambulance can be cancelled later if not needed.

115. There was a delay of three minutes in calling a code blue for Ms Adams. At 3.49pm, a manager called for healthcare when he found Ms Adams but did not call a code blue. A governor called a code blue three minutes later when she arrived at Ms Adams cell. There is a discrepancy between the control room log and ambulance records about the time an ambulance was called. In an emergency, even a short delay in calling an ambulance can have a significant impact on a person's chance of survival. We make the following recommendation.

The Governor and Head of Healthcare should ensure that all prison and healthcare staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies as outlined in the local Medical Emergency Response Code Protocol so that staff efficiently communicate the nature of a medical emergency, and there is no delay in calling, directing or discharging ambulances.

116. The inquest, held from 8 to 19 April 2024, concluded that Ms Adams died from misadventure. The jury found that the following contributed to her death:

- The prison's mental health team were not always invited to ACCT reviews, did not attend any ACCT reviews, and only contributed to two (out of 64) by telephone. This omission possibly contributed as the mental health team could have given a fuller picture of Ms Adams' current mental health state, which may have informed the decision-making process.
- On 11 November 2016, Ms Adams was placed in cellular confinement in a cell with a fixed shower rail. This probably contributed because the shower rail is a prominent ligature point that she had used previously, and it was also out of sight of prison officers.
- There should not have been a gap of 29 minutes in observations between 3.10pm and 3.39pm on 12 November. This omission possibly contributed because it provided Ms Adams a greater opportunity to ligature and not be discovered and not receive medical attention sooner.

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