The Prisoner Ombudsman for Northern Ireland

# REPORT BY THE PRISONER OMBUDSMAN INTO THE CIRCUMSTANCES SURROUNDING THE DEATH OF FRANCES MCKEOWN WHO DIED WHILST IN THE CUSTODY OF HYDEBANK WOOD WOMEN'S PRISON ON 4 MAY 2011 AGED 23

**[22 November 2012]**

**[Published: 28 November 2012]**

**Please note that where applicable, names have been removed to anonymise the following document.**

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## PREFACE

Frances McKeown was born on 28 April 1988. She was 23 years old when she died by suicide[1] on Wednesday 4 May 2011, whilst in the custody of Hydebank Wood Women's Prison.

With the agreement of her husband, I have referred to Frances McKeown, throughout this report, as Frances. I offer my sincere condolences to Frances' family for their loss. I have met with Frances' family and shared the content of this report with them and responded to the questions and issues they raised.

As part of the investigation into Frances' death, Dr Seena Fazel, Consultant Forensic Psychiatrist and Clinical Senior Lecturer in Forensic Psychiatry at the University of Oxford, was commissioned to carry out a clinical review of Frances' medical treatment whilst in prison. Dr Malcolm VandenBurg, a specialist in General Medicine and Consultant Pharmaceutical Physician also assisted with some specific queries relating to Frances' medication. I am grateful to Dr Fazel and Dr VandenBurg for their assistance.

It is my normal practice to access relevant hospital notes when conducting Death in Custody investigations. Because of the particular circumstances of this case, letters of administration were required to confirm the lawful authority of the next of kin in order to authorise the release of Frances' hospital notes. This resulted in a substantial delay. When the notes were finally received in May 2012, I asked Dr Fazel to review them and produce an addendum to his Clinical Review Report.

Early in the investigation into Frances' death, I became aware that, on the 17 January 2011, a member of her family had written to Hydebank Wood Prison outlining concerns that Frances had said that she had witnessed inappropriate behaviour involving a prison officer and an inmate and that she was going to "*get beaten by the lady in question.*"

I also received an anonymous letter from a "*concerned staff member*" at Hydebank Wood who alleged, that Frances McKeown had been bullied and threatened by other inmates.

[1] The circumstances surrounding Frances' death presents as a self inflicted death, however it should be noted that the Coroner's verdict is pending at the time of this report's publication.

During the course of the investigation, it became evident that others believed that some inmates had treated Frances in a way that could be described as bullying. This was said to have occurred because inmates believed that Frances had told the security department at Hydebank Wood that she had seen a male prison officer kissing a female inmate. Concerns were raised that Frances' treatment by some prisoners might have contributed to her death.

The Prisoner Ombudsman determined that all of these matters and concerns should be investigated and further information is included at Section 15 of this report.

In the event that anything else comes to light in connection with this or any other matter addressed in the investigation, I shall produce an addendum to this report and notify all concerned of the additions or changes.

A detailed account of all of the evidence examined during the investigation has been included in the main body of the report. This is particularly to assist Frances' family; the South Eastern Health and Social Care Trust; the Prison Service and the Coroner. For other readers who do not wish to consider all of the investigative detail, a comprehensive summary has been included.

It is my practice to make recommendations for action that might lead to improved standards of inmate care and may help to prevent serious incidents or deaths in the future.

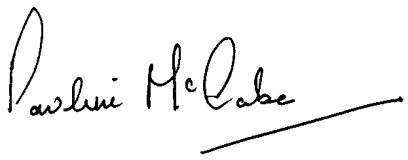
In February 2011, in her interim report, 'Review of the Northern Ireland Prison Service', Dame Anne Owers said that *"An early task for the change management team will be to rationalise and prioritise the outstanding recommendations from the various external reviews and monitoring bodies. They have become a barrier rather than a stimulus to progress, with a plethora of action plans at local and central level, and a focus on servicing the plans rather than acting on them. This has led to inspection and monitoring being defined as a problem within the service, rather than a solution and a driver for change."*

In light of Dame Owers' comments, and in order to support the development of a more strategic and joined up approach to service development, I decided in June 2011 that I

would not make recommendations in connection with Death in Custody investigations but would instead detail issues of concern that I would expect the Prison Service and SEHSCT to fully address, with appropriate urgency, in the context of their programmes for change or/and normal governance arrangements. I shall keep this approach under review and revert to making recommendations if I am not satisfied that the response of the Prison Service and/or Trust is appropriate.

In the case of Frances McKeown, **eighteen** matters of concern have been identified.

I would like to thank all those from the Northern Ireland Prison Service, the South Eastern Health and Social Care Trust and other agencies who assisted with this investigation.



**PAULINE MCCABE**
**Prisoner Ombudsman for Northern Ireland**
**22 November 2012**

## SUMMARY

Frances McKeown was born on 28 April 1988. She was 23 years old when she died by suicide, on Wednesday 4 May 2011, whilst in the custody of Hydebank Wood Women's Prison.

At around the age of 13, Frances was referred to community mental health services. She subsequently started to self harm. Frances' family said that, throughout her secondary school years, she was bullied *"quite badly"*, but after leaving school she achieved a diploma in child care and had a part-time job.

At 18 years of age, Frances' family said that she *"drifted away"* from them and she stopped engaging with community mental health services.

At 19, Frances met her husband and had their first child. Following the birth of their child and difficulties with their marriage, Frances and her daughter moved away from the family home. After the birth of Frances' second child, she experienced further difficulties and her family said that they felt that she was suffering from post natal depression. As a result of these difficulties, both children were taken into care.

After Frances' children were taken into care, and following an earlier allegation that she was the victim of sexual abuse, Frances' mental health deteriorated and as a result she was admitted to Craigavon's Bluestone Mental Health Unit. Frances was subsequently admitted to Bluestone on a further ten occasions. It was during these admissions that she was diagnosed with Emotionally Unstable Personality Disorder.

Frances' GP records show that in the 12 months prior to her committal to Hydebank Wood Prison she: had low mood and had self-harmed on a number of occasions by taking overdoses (Paracetamol) and cutting herself; was distressed by the murder of an ex-boyfriend; and was again under the care of a community mental health team.

On 22 September 2010, Frances was remanded into the custody of Hydebank Wood. This was the first time that she had been in prison. Frances' Prisoner Escort Record, which accompanies an individual committed from police custody, notes that she

*"suffered from depression and anxiety. Attempted self-harm 6-8 weeks ago. States currently feeling suicidal..."*

There is no evidence that prison staff assessing Frances as part of the committal process received or considered this information. Staff did note Frances' history of psychiatric hospitalisation; an attempted suicide six weeks previously; a history of illegal drug and alcohol misuse and that Frances had no "*current thoughts of self-harm".* It was noted that Frances' demeanour was appropriate, cheerful and co-operative. It was also recorded and confirmed with her GP, that she was taking Risperidone[2] 4mg daily prior to her committal. Her medical records were not, however, requested from her GP.

The prison doctor, who then prescribed Frances' Risperidone, did so without seeing and assessing her. Commenting on this in his clinical review, Dr Fazel said that as the prison represents a new environment and the first weeks in custody are known to be a difficult time, it was his view that an early, face to face medical assessment is very important where antipsychotic medication is prescribed.

Taking account of Frances' Risperidone prescription and psychiatric history, Dr Fazel also stated *"I would have thought that Ms McKeown should have been seen urgently by a mental health nurse within a week of committal, and within two weeks of a referral from a mental health nurse by a psychiatrist."*

It was the case that a referral to the mental health team was made within a week of Frances entering prison and that a further referral was made on 30 September. Frances was, however, not seen by a member of the mental health team until 8 November 2010, six weeks after the first referral was made. At interview, Frances' mental health nurse said that this was because, at the time, the mental health role was not *"ring fenced,"* which meant that she was also assigned to carry out other general nursing duties throughout the prison. The nurse did say, however, that at times where an urgent mental health assessment was requested by a colleague, she would have asked for the time to assess the individual that same day. She said that she did not receive an urgent request in the case of Frances.

[2] Risperidone – an oral medication that is used as a major tranquilizer or antipsychotic.

Between 25 and 27 September 2010, staff did however recognise that Frances was not settling well in prison and she was seen by Opportunity Youth[3] for crisis intervention support on each of these days. Records of these sessions note that although Frances presented as being in *"good form"*, she was "*not in a good place. Does not like being locked up."* It is noted also that "*Frances is annoyed with another inmate."* During the first two sessions, Frances was finding it hard to refrain from cutting herself and alternatives to cutting were discussed with her and an officer on duty. By the third session, it is noted that Frances had no thoughts of self-harm or suicide and was keen to continue to engage with Opportunity Youth.

On 28 September 2010, Frances was referred to the mental health team because she was having difficulty sleeping. The referral was to support her in addressing any issues in respect of her sleep routine, before giving consideration to the prescription of sleeping tablets.

On 29 September 2010, a SPAR booklet[4] was opened because Frances had cut her arms. This SPAR booklet remained open until 5 October 2010 and was the first of five to be opened during Frances' time in Hydebank Wood. Care plans, to help support Frances at times when she was considered to be vulnerable and at risk, were put in place on each occasion that Frances had a SPAR booklet opened.

As stated, Frances was eventually seen by a mental health nurse on 8 November 2010. During her assessment, the mental health nurse noted that Frances had been a psychiatric patient 11 times, was currently an outpatient and had two infants in foster care. Frances disclosed a history of alleged childhood sexual abuse, domestic violence and self-harm and explained that she felt better on Quetiapine 125mg (an antipsychotic drug) and Fluoxetine 40mg (an antidepressant). The mental health nurse recorded on EMIS[5] that a referral to psychiatry would be required, in order for Frances' medication to be reviewed.

[3] Opportunity Youth provide a comprehensive range of personal development and therapeutic services, including three one to one intervention sessions for those inmates who are finding it difficult within their first week of prison.
[4] Supporting Prisoners at Risk (SPAR) booklets are used at times when staff deem an inmate as vulnerable to self harm and suicide to provide increased observations and support for inmate.
[5] EMIS – Egton Medical Information System – an electronic medical records system used by the healthcare department of the Northern Ireland Prison Service.

The day following her assessment, Frances was prescribed Fluoxetine by a prison doctor but, regrettably, the requirement for a referral to psychiatry was not actioned because of an oversight by the nurse.

Frances' second SPAR booklet was opened on 13 November 2010, because Frances had thoughts of suicide and was considered to be *"really at risk."* The following day, Frances had a SPAR assessment interview with a senior officer. The senior officer recorded that Frances clearly had a suicide plan and had felt suicidal during the night. She noted that Frances *"gives me grave cause for concern as she is withdrawn,"* and still appeared to be at high risk of suicide because she was *"uncommunicative and morose…appears depressed and continued to voice negativity to all our suggestions."*

A decision was taken on 14 November 2010 to keep Frances in an observation room in order *"to keep her safe."* Frances' care plan was updated to include supervised access to her possessions in her room. Frances refused to move to the observation room when asked. A nurse who was in attendance at the SPAR case review, and knew that Frances had a good rapport with her mental health nurse, asked the nurse to come and speak with Frances. This approach worked well and Frances was eventually moved without causing her distress. This SPAR was closed on 26 November 2010.

Frances' third SPAR booklet was opened nine days later, on 5 December 2010, when she reportedly took an overdose of 42 Paracetamol tablets which she had been requesting for headaches and then storing. Frances had further consultations with a mental health nurse on 6 December and 10 December 2010 and the SPAR was then closed on 14 December 2010.

The investigation established that on 14 February 2011, a medication spot check was carried out and Frances was found not to have any of her prescribed medication in her possession. As a result, the prison doctor stopped her medication pending a mental health assessment and a referral form was completed. The doctor said, at interview, that because Frances couldn't explain where her tablets were, she thought *"if I didn't know where the tablets were going wouldn't it be better that she didn't have any tablets than somebody coming up [and bullying her for them]."*

The doctor was asked whether alternative options, such as placing Frances on daily supervised swallow of her tablets, was considered. She said *"the nurses organise all of that. And sometimes the women don't like that. How they give out the tablets is the nurses' decision."* The doctor said also that she had thought that Frances would have a mental health assessment within a couple of days.

It is, in fact, the case that, in the absence of a doctor's prescription, the nurses would be unable to give medication to Frances and could not, therefore, consider administering it in a different way.

On 2 March 2011, it is recorded that landing staff notified a nurse that they were concerned about Frances' mood being low. The nurse recorded on EMIS that Frances had still not had a mental health review and requested that the doctor see her and recommence the antidepressant medication which had previously been stopped.

On 3 March 2011, landing staff recorded that Frances was *"upset, tearful and feels her head is going….she feels she can hear voices and wants to go back to her old ways of cutting her arms."*

Although the doctor stated that she expected a mental health assessment to take place within a couple of days of stopping Frances' medication on 14 February 2011, in the event, Frances was not seen by a mental health nurse until 4 March 2011 and was not put back on her medication until 5 March 2011. She was, therefore, without antipsychotic and antidepressant medication for 19 days.

Frances' fourth SPAR was opened on 4 March 2011, following her period without medication. It was opened because of her low mood and thoughts of suicide and because she was "*hearing voices in her head.*" It is to note that, although SPAR booklets had previously been opened for Frances on 13 November and 5 December 2010, and she had further consultations with a mental health nurse on 6 December 2010, 10 December 2010 and 4 March 2011, the fact that she had not received her appointment to see the psychiatrist was not followed up.

On 4 March 2011, because Frances disliked being held in an observation cell, staff who were concerned that she was at risk of self harm, decided that she was to be

placed in an empty room with her own clothes and bedding and to be observed at intervals of no more than 30 minutes.

On 5 March 2011, it was agreed for Frances' own safety and that of others that she would be moved to the healthcare centre *"to give her time to re-coup her thoughts and re-adjust her thinking."* It was noted that *"Frances is in a really bad place at present. She has stated that she will kill someone, maybe even herself".* It was also noted that Frances had said that *"smiling at staff and appearing upbeat had fooled staff."* In response to Frances' feelings of anger, a referral was made to Opportunity Youth.

On 11 March 2011, it was noted that Frances was progressing well in the healthcare centre and was to have a phased return to *'normal'* location. This involved her returning to her landing during the day time.

Eventually, a further psychiatric referral was made on 20 March 2011, and followed up on 21 March with an urgent referral, because Frances had written a letter noting that her suicide plan was *"imminent and live."* In the letter she talked about her "*normal problems*" which she listed as relating to her childhood, family, marriage, kids and the murder of a previous boyfriend. She went on to say:

*"… my problems are now things I haven't suffered from since I was about fifteen. It's the thoughts I'm having and the voices I'm hearing. I have non stop thoughts about seriously hurting people and even killing people. I think everything out to the finest detail of what I would do, and I don't care if I get caught, I just want to hurt people including myself …"*

*"… the voices in my head are getting worse and more violent, they run me down and make me so angry. It's like I'm sitting on my own but there is someone in the room with me telling me what to do and to hurt people and I have to fight it's so hard, not to try and listen to it. At night when I am in my cell it is worst because I can't distract myself from it all I can do is listen to it and the horrific things it tells me to do. Hell every day of my life and if I am dead it would all be over for me and I wouldn't have to suffer anymore because I can't put up with it any longer.... I can't do it anymore, I'm done trying, I just want to die and end it all. I can't put up with it anymore. It's too hard and to tiring. JUST LET ME DIE!!!"*

On 20 March 2011 also, a case review was convened. Frances again refused to move to an observation room when it was agreed that this was necessary. On this occasion, Frances was forcefully put into the room using Control and Restraint techniques.[6] There is no recorded evidence that, as required by Prison Service policy, other means of persuasion, such as that used on 14 November 2010, were considered or tried. A nurse, who another inmate said used to talk with Frances and listen to her problems, was reported by a senior officer to be *"very down and upset"* about Frances being relocated in this way.

Whilst it is an overriding priority that those who are at risk are protected, the Prisoner Ombudsman has previously raised concerns about the manner in which Control and Restraint procedures are, at times, used at Hydebank Wood to move vulnerable prisoners, before all other options have been exhausted. This matter is currently under review.

As a very vulnerable prisoner, Frances should also have been reviewed by the Hydebank Wood's Safer Custody Team. The role of the Safer Custody Team includes the protection of vulnerable prisoners, the prevention of self-harm and suicide and the reduction of violence. Referrals to the Safer Custody Team can be made by any member of staff who is concerned about an inmate. Frances' vulnerability was highlighted as soon as she was committed to prison and it might reasonably have been expected that staff would have considered her referral to the Safer Custody Team at that point, or when her first SPAR booklet was opened on 29 September 2010. Frances was not, however, referred to the Safer Custody Team until 15 March 2011, almost six months after she arrived at Hydebank Wood.

*O*n 25 March 2011, a prison psychiatrist, in order to prioritise her waiting list, spoke to Frances' mental health nurse to find out how *"urgent"* the requirement for Frances' assessment was. At interview, the psychiatrist said that when she spoke to the nurse it was decided that Frances was no longer an *"urgent"* case and would be seen on her return from a period of leave. The psychiatrist asked the nurse to obtain Frances' community psychiatric notes, in preparation for the assessment.

[6] Control & Restraint (C & R) techniques may only be used when verbal persuasive methods have failed, to protect persons or property, to prevent an escape or recapture an escapee or to overcome a threat to the good order of the establishment.

Frances' fourth SPAR was closed on 1 April 2011.

From April 2011 until she died, Frances wrote a personal journal, which she titled *"Life as a Highbanker."* The journal provided insight into how Frances was feeling, her plans to die by suicide and what life in prison was like for her. Excerpts from Frances' journal are included in Section 11 of this report.

In her journal Frances wrote of the benefits of keeping busy and going to work (in the garden/craft centre) on her mental wellbeing and of how being locked in her room gave her too much time to think. Talking about her early weeks in prison she wrote: *"the more time I spent on my own the worse the voices got and the worse the voices got the more I self-harmed to stop them. I literally cut myself to ribbons or clawed myself to pieces."*

On 7 April 2011, Frances was first discussed at a Safer Custody Case Conference and a number of important decisions were made. These included taking actions to: request a history update from Social Services; invite Frances' social worker to the next meeting; request a progress report from Frances' cognitive behavioural therapist; refer Frances to the prison psychiatrist and ask for feedback; organise support through Opportunity Youth and to ascertain whether Frances would be suitable for an anger management programme. It was agreed that a further review should be carried out two weeks later.

On 12 April 2011, six and a half months after she was committed to prison, Frances was seen by the psychiatrist. Frances' community psychiatric notes were not, however, available for this assessment because they had not been obtained by her mental health nurse, as requested on 25 March by the psychiatrist. The healthcare department at Hydebank Wood does not have any administration support and, at interview, the nurse said that the notes were not requested because she was not allocated time to carry out this type of follow-up work.

It is to note that, in May 2011, after Frances' death, a full time mental health post was provided for Hydebank Wood by the South Eastern Health and Social Care Trust.

The psychiatrist, who saw Frances on 12 April 2011, recorded a summary of her consultation and noted that she would complete her assessment *"once I get her old notes. She remains on my list."* At interview, she said that it was *"extremely difficult"* not having the previous notes which would have given her *"the opportunity to see what antipsychotics* (medication)*, she used before."*

The psychiatrist noted that Frances had been threatening self-harm since coming to Hydebank Wood; that she said she planned to take her own life when she left prison and that she had been "*hearing voices"* since 2009. She noted also that Frances said she has been in Bluestone Mental Health Unit a number of times and had been diagnosed with Emotionally Unstable Personality Disorder.

The psychiatrist assessed Frances as *"calm but appeared guarded"* and *"feeling a bit anxious."* She noted that Frances' sleep was poor and that she had said she was "*very low*" and had "*no motivation"*. She noted also that Frances reported "*hearing voices in her head*" telling her that she was "*worthless"*, that "*no one would miss her"* and that she would "*lose custody of her children*".

On the basis of her partial assessment, the psychiatrist increased Frances' antidepressant medication (Fluoxetine).

On 14 April 2011, Frances met separately with a probation officer and Opportunity Youth. It is recorded that during both meetings, Frances made comments about her active suicide plan to kill herself once she was released from prison. It is also recorded that Frances said to her probation officer that she *"was biding her time until she gets an opportunity to do it right – she is content to wait until that opportunity presents itself."* It was noted that Frances did not present as being *"emotional or upset or even presenting as depressed more that she is content with the decision she has made and as such has some comfort from that."* It is also recorded that the probation officer spoke to the senior officer in Ash House and relayed the above information to him.

The next day, on 15 April 2011, Frances' fifth and final SPAR was opened because she had low mood and thoughts of suicide. It remained open until 19 April.

On 21 April 2011, a further Safer Custody review took place and those in attendance were given valuable insight by her social worker into: Frances' background; her alleged childhood trauma; her relationship difficulties; the reasons why her children had not been returned into her care and her diagnosis of Emotionally Unstable Personality Disorder.

It is apparent from her journal entries that between 23 April and 2 May 2011, when there were a number of Public and Bank Holidays due to Easter, the Royal Wedding and May Day, Frances found her days *"long"* and *"tedious,"* because she could not *"go to work"*.

On 24 April 2011, Frances wrote, *"… because I suffer from mental health my time for thinking is my biggest problem, when I have too much time to think on my hands that is when my mood lowers severely and I become suicidal. My thoughts make my mind snap and I just can't cope with it anymore so I self-harm to try and stop it and block out the thinking and sometimes I even go far enough to plan a new way to end it all just to stop my pain from my thoughts. Once I lose the head and cut I end up on a SPAR and have to put up with being watched which makes my paranoia worse and the voices I hear go mad because of it and I stress out. It is the worst combination of emotions you could possibly imagine…..It is so uncontrollable and even to this day it scares me every time it happens and I have never been able to get control of it or used to it. The demons I suffer from I wouldn't wish on my worst enemy, it is a living nightmare. I do have good days, but they are few and far between, my life has been engulfed by turmoil and heartache. Since I have become a Highbanker I have had to face up to my problems a lot more since I can't use drink or drugs to block them out. The healthcare in here is lethal, they are useless and don't care about the welfare of the inmates. They just do no more than they have to, to get through the day so we rely on ourselves to sort our own problems out..."*

Frances also wrote, *"… I have a long term goal in life and it isn't to live. It is to die but it is not for a few years yet. It is something I have been contemplating and planning from I was 13 years old and now I know my plan of action down to the last detail …"*

On 25 April 2011, Frances wrote, *"… today is going to be a long boring day but there is no point complaining because nobody listens anyway. I don't think I'm going to bother*

*eating today I have gone back into one of my funny moods again, which is the start of one of my bouts of depression. So my long cycle starts all over again. It is quite frustrating knowing I am going to suffer a bout of depression and suicidalness but I can't do anything to stop it. It is tiring.…"*

On 1 May 2011, Frances appeared to be having a better day and wrote, *"… sometimes it is hard but like today it was a relaxed day so it wasn't bad or too hard to cope with. Surprisingly I am having a relatively good run at the minute with my mental health. The voices are good and keeping me company and I have no thoughts of wanting to self-harm at present so that is good."* Frances did however write of her concerns about her *"two beautiful babies"* and how she thought that she would never be fit to look after them *"and that they will be better off without me and with people who can look after them and give them everything they need. I will always love my babies but I am just too sick to be able to look after them …"*

On 3 May 2011, the day before she died, Frances started an Opportunity Youth drug and alcohol program. A record of the session notes that Frances participated well in the group – listening, taking part and contributing.

During her last telephone call on 3 May, Frances talked to her husband about their relationship and visiting numbers for the coming week, two of which she said she had sent to her parents and two she had kept for him. Frances also mentioned that there was due to be a court hearing regarding custody of their children the next day.

In her personal journal, Frances noted, *"… today has been a good day. I started OCN (Open College Network) in exploring behaviours course and we looked at drugs and alcohol. I have to go again tomorrow and two days next week.….Then locked for the night and I wrote a letter to* (her husband) *and rang him as well. Was good to talk to him again. I do love and miss him …"*

On 4 May 2011, Frances had a further Opportunity Youth OCN programme session, which was again followed by a one to one session to ascertain how she felt it had gone. A record of this notes that *"Frances said she spoke in front of the group about herself and it went really well, she communicated to others regularly throughout the group and said she enjoyed taking part. Frances said she was feeling good and realised she*

*deserves to get her kids back, have a job and is proud of herself for getting off drugs and alcohol. Meet tomorrow."*

An officer who was working on Frances' landing that day described her as being *"bubbly"* and said he had managed to get her a job painting the landing and rooms, which she was looking forward to starting the following Saturday.

At 17.00 on 4 May 2011, Frances' landing was unlocked to have their tea. Within a few minutes an emergency alarm went off in Elm House[7] and a 'code blue'[8] was called over the prison tannoy system. Because of this, Frances and the other prisoners from her landing were locked up. At interview, some inmates said that when Frances knew that they were going to be locked up early she was angry and one inmate said that she commented that "*he* (the prisoner who had triggered the code blue) *could have done it at lock up.*" Another inmate said that Frances said *"something like, that's another night I'm going to be locked up. I can't be f***king bothered to be locked up again."*

Another inmate said that the last thing Frances said to her on 4 May 2011 was *"I can't take any more of these lock-ups."*

An inmate who was very close to Frances at the time of her death said at interview that: *"the week before she died we were playing football up in the fields and we had a great laugh. She was in good form. The night before she died she was singing and dancing in my cell. I don't know whether it was a cry for help... I think there were far too many lock ups. I don't know why we were being locked just because the boys were being locked. When an alarm went off in one of the boys houses, we would be locked straight away."*

The 'code blue' incident concerned the death of a young man in Elm House.

CCTV shows that at 17.24 on 4 May 2011, inmates left their rooms to collect their tea meal and fill their hot water flasks. At 18.05, CCTV shows that all inmates had returned to the landing and were locked. From 18.54 two landing officers moved between the landing and kitchen, filling up inmates flasks again, taking out their

[7] Elm House is one of the accommodation blocks for the male young offenders who share the same site as the women's prison.
[8] Code blue means that there is a medical emergency to alert medical staff to the type of response required. There are a number of reasons why a code blue would be announced including when a casualty is unresponsive to voice or has a ligature.

dinner plates and taking cartons of milk and small boxes of cereal for those inmates who had requested them for their supper. At interview, one of the officers said that, when asked, Frances said that she did not want any cereal or milk. The officer said that she remembered Frances was sitting writing at her desk at the time.

At interview, an inmate said that at about 19.00 she heard Frances *"watching Emmerdale and singing the lazy song."*

During the evening of 4 May, Frances wrote the following in her personal journal:

***'TIME TO DIE'***

*"Today has been an ok week and day except this evening the voices are getting really bad. I can't put up with them much more. There was a code blue tonight on the wee lads house Elm. Code blue is when someone has hung themselves and died, so we are locked all night. If these voices keep up there will be another code blue tonight. I already have my noose made and ready but I can't do anything until the night staff do the alarms* [referring to the head count check which is routinely carried out at around 19.30]. *Then I have an hour….I've got it planned and tonight is the night."*

At 19.25, the officers left the landing and the grill to the landing was closed over.

CCTV shows that at 19.31, one of the two night custody officers on duty in Ash House went down the landing to carry out a head count check. At interview, he said that when he first looked into Frances' room he could not see her. He said that he called her name to see if she was there and Frances, whom he states was over to the left of her room, as though she was kneeling down or sat on her chair, leant back and waved to acknowledge the check that the officer was carrying out. He said that she didn't speak to him but, *"I was just looking for a response and I got that so I moved on to the next inmate."*

At 20.38, CCTV shows that, following another head count check, the other night custody officer on duty could not see Frances in her room and could not get a response and shortly afterwards an emergency unlock was carried out.

On entering Frances' room, she was found unresponsive with a ligature tied around her neck and attached to a point in her room. The officer immediately cut the ligature and, with the assistance of her colleague, manoeuvred Frances out onto the landing in order to check for vital signs and commence cardio pulmonary resuscitation (CPR). The second night custody officer, who attended the unlock of Frances' room, was able to describe to the investigation how he knew that Frances' airway was blocked.

CCTV shows that, within two minutes, the senior officer, shortly followed by a nurse, arrived at the scene. Less than a minute later, another night custody officer, who had responded to a radio communication of the emergency, arrived. No 'code blue' was used in this instance.

CPR continued and a heart start defibrillator was attached to Frances. Accounts from all in attendance confirm that, at no point, were there any signs of life.

At 20.56, CCTV shows paramedics attended the landing. Accounts from staff in attendance confirm that CPR continued but, again, there were no signs of life.

At 21.10, CCTV shows a doctor and cardiac team arriving on the landing. At 21.17, the doctor pronounced Frances dead.

In a letter, titled *'My Suicide Note'* which was found in Frances' room, Frances apologised for what she had done and wrote of her children whom she said she *"loved with all my heart and soul and will always be with them."* Frances included in her note messages for her husband and parents and another inmate in Ash House whom she had become very close to. In her final words Frances wrote: *"… this is nobody's fault, it is my choice to die. People wouldn't listen to me when I told them how bad the voices I hear were and I just can't put up with it anymore. I'm so sorry. Goodbye. Frances."*

Considering possible reasons for Frances death on 4 May 2011, Dr Fazel said that: *"on the basis of the background history, Ms McKeown had a number of risk factors that indicate an increased risk of suicide in custody. These include a history of recent suicidal thoughts and attempted suicide before custody…..a current psychiatric diagnosis, and a history of reported sexual abuse."*

It is to note that, at interview, staff members and inmates gave many examples of Frances, throughout her time in prison, talking about her plan to die by suicide.

As explained, it was also the case that Frances had a number of recent stress factors. Her two infant children were being fostered and their future custody arrangements were uncertain, she had some problems with her family and an ex-boyfriend was murdered three weeks before she came into custody. In her last phone call to her husband, on the day before her death, she made mention of the court proceedings the following day at which her children's custody would be discussed.

Dr Fazel said that it was his view that these recent *"stressors"* and future anticipated problems in the background are part of any formulation about the reasons for her untimely death. It was also the case that, following a conversation with her solicitor, Frances apparently believed that she might receive a sentence of four to five years which had upset her, as she was apparently expecting one year.

Frances' suicide note focused on her symptoms worsening (*"the voices are getting really bad"*) and not being able to cope.

Writing about her mental health in her journal, 1 May 2011 Frances explained that *"it starts with me starting to feel low and down, that is when the voices start to get derogatory and really nasty. They call me names and tell me to do things.....My mood continues to get lower and the voices get worse and that is when I start contemplating self-harm and suicide.....If the self-harm doesn't take the pressure off my mood and the distress I'm in then I start contemplating how to go about killing myself.....my plan is not to die in a place like this but if things continue to get so bad for me, then I will end up topping myself in here... My mental health has been a constant battle for me my whole life from as far back as I can remember. It has always been an epic struggle and I have lost on so many occasions and probably will lose on so many more....As I was explaining before I have plans to die. They are complex plans with complex reasons behind them but I am intent and determined to carry them out....Even the voices in my head have agreed with my plan. It is just a matter of timing. It will all take place exactly two weeks after I am released from Hydebank ..."*

Frances wrote also *"I have been dealing with the system for so long I can bluff my way through it with my eyes closed. The system and the doctors are no match for me because I can always tell them what they want to hear. If I told people how I truly felt then I would be locked up in a mental house for the rest of my days."*

Frances' closest friend in prison said that Frances had told her that it was her intention to die after she left prison and a number of factors might suggest that Frances' actual decision to die by suicide on the evening of the 4 May 2011, was only taken on that date.

On the day before her death, Frances' parents received visit numbers for the two weeks following her death and a request for money and, in her phone call with her husband the day before her death, she mentioned that she was about to send him visit numbers also. Furthermore, Frances' personal diary entry of 3 May 2011 stated, *"went to OCN course, went well…today has been a good day….I have to go again tomorrow and two days next week…"*

Frances was also reported to be *"looking forward to starting"* a painting job that had been set up for her.

It is to note also that in her suicide note, Frances made reference to a death of a young man at Hydebank Wood that occurred a few hours before her suicide. Frances was reported to be upset that the death of the young man resulted in her, once again, being locked. It is one possibility that the occurrence of this death may have affected Frances' mood.

It is also a possibility that the fact that Frances was found, at autopsy, to have taken the non-prescribed antidepressant Trazodone, could have influenced her decision. The clinical reviewer Dr VandenBurg pointed out that Frances may have been using Trazodone for its sedation effect, because she had difficulty sleeping. He said also that *"patients with a history of suicide-related events, or those exhibiting a significant degree of suicidal ideation prior to commencement of treatment with Trazodone are known to be at greater risk of suicidal thoughts or suicide attempts, and should receive careful monitoring during treatment",* particularly in the early stages of its use.

Dr VandenBurg also pointed out that Frances' prescribed medicine, Fluoxetine is subject to similar warnings. He said, therefore that in relation to Frances, particularly as she was under the age of 25, *"there would have been a summation of effects, if not true enhancement."* Dr VandenBurg said that there are reported cases of suicidal ideation and behaviours when Fluoxetine and Trazodone are combined.

Noting that Frances was prescribed the antipsychotic medication Risperidone, Dr VandenBurg said also that *"the manufacturers warn in generality that the sedative effects of the antipsychotic and Trazodone may be intensified when prescribed together and that is why Frances may have been using Trazodone for the sedation of it alone and the sedation in combination with the Risperidone."* As stated previously, it was the case that Frances had difficulty sleeping at night.

Dr VandenBurg further said that administration of antidepressants in patients with psychotic disorders may result in a possible worsening of psychotic symptoms and paranoid thoughts.

Dr VandenBurg said *"In summary it may be highly significant that Frances McKeown was abusing Trazodone because of its own effects on suicidality and its own adverse experiences, all of which could have been increased by the prescription of Fluoxetine and Risperidone....In the unmonitored environment with potentially varying doses of all drugs, the combination could have been disastrous."*

A summary of Dr VandenBurg's report is in Section 17.

In his clinical review, Dr Fazel also raised some concerns in relation to the management of Frances' prescribed medication. He noted that on committal, Frances' GP was phoned and the correct dose of her Risperidone was given, which he said was *"good practice."* However, after six weeks in custody, and reports of low mood and suicidality, Frances explained to her mental health nurse that she had felt better previously on a combination of Quetiapine 125mg (an antipsychotic) and Fluoxetine 40mg (an antidepressant). The following day a prison doctor prescribed Fluoxetine 20mg but would not prescribe a new antipsychotic drug (Quetiapine) without input from a psychiatrist. As stated earlier, no psychiatric assessment took place until 12 April 2011.

Dr Fazel said that Fluoxetine 20mg was *"an appropriate starting dose, but this was only increased on 12 April 2011 to 40mg when she was seen by the psychiatrist.* Dr Fazel stated, *"It may have been beneficial to her to have the dose increased earlier, and I note that [a nurse] recommended this on 27 November 2010 but this does not appear to have been followed through."*

Commenting on the doctor's decision to stop Frances' medication on 12 February 2011, Dr Fazel said that this was *"not appropriate"* and *"there is no clear rationale for this." "There are",* he said, *"a number of questions raised by this course of action. First, Ms McKeown's explanation for the missing medication is not recorded. Second, although the prison doctor stopped her medication, she requested a mental health review but this did not occur for a further three weeks. The prison doctor did not appear to chase this up. Third, on stopping her medication, the prison doctor writes 'needs them???' which seems to contradict her psychiatric history (which suggests that she has been prescribed these medications for many years by specialists). Fourth, such a course of action could have been discussed with the prison psychiatrist. Fifth, I am not aware of Risperidone being used in this way, as it is not a drug of abuse in the community. Finally, an alternative was not apparently discussed with Ms McKeown of having to take her medication in front of staff or having it daily in possession…."*

Dr Fazel noted also that, following her medication being stopped, the prison doctor's next meeting with Frances is recorded to be as a consequence of low mood and suicidal ideation, suggesting a deterioration of her mental state, following her medication being stopped. A SPAR assessment on 4 March 2011 notes also that Frances said that she had been hearing voices and that when she thinks about suicide, the voices are *"nasty."*

Commenting on Frances' mental health and psychiatric assessments, Dr Fazel said that in his opinion the delays that occurred were *"not appropriate."* In relation to the quality of the assessments themselves, once they were undertaken, Dr Fazel stated *"I believe overall the nursing assessments appear to have been done appropriately."* He also stated that whilst it was difficult to assess the one psychiatric assessment, the psychiatrist *"covered important parts of her [Frances'] history and current mental state."*

Notwithstanding these concerns, it is the case that Frances received professional support through a number of therapeutic interventions during her time in Hydebank Wood. These included Cruse bereavement counselling, to help her to deal with the death of a previous boyfriend; NEXUS sexual violence/abuse counselling; Opportunity Youth one to one counselling and drug and alcohol support; and cognitive behaviour therapy sessions. Dr Fazel said that *"this is good practice as individuals who are on the more severe end of the spectrum of personality disorder (as I think Ms McKeown was) are unlikely to benefit from medication solely, and psychological treatments are recommended by NICE[9] and other expert opinion."*

As reported in previous Prisoner Ombudsman Death in Custody Investigation Reports, time out of cell has been repeatedly shown to be very important in the care of vulnerable inmates at risk of self-harm and suicide. A review of Frances' SPAR booklets found a large number of recorded observations which suggest that, consistent with best practice for caring for vulnerable prisoners, efforts were made to ensure that Frances engaged in a number of activities which provided her with time out of cell, including: working in the prison garden; working in the cottage industries making crafts and cards; attending education classes in art, music and hairdressing and going to the gym. There was also evidence of staff taking time to talk with Frances.

There was, however, evidence that Frances found night time and other times when she was locked in her cell very difficult. It was clearly the case that she found the lockdowns over the period of Easter and the Royal Wedding, which preceded her death, very testing.

All of Frances' SPAR case reviews were well attended by staff from a number of departments throughout the prison, though some case review summaries did not include details of what was discussed or how and why actions were agreed.

For much of the time, Frances was observed at the intervals required by her care plans; however, there was evidence that, at times, observations were not carried out at the required intervals. During the period 29 September to 5 October 2010, when Frances should have been observed at intervals of 30 minutes, she was, on three occasions, observed after 45 minutes, on one occasion after 50 minutes and on 12

[9] NICE – National Institute for Clinical Excellence.

occasions after intervals of approximately one hour. There are also single instances of observations only taking place after one hour 15 minutes, one hour 30 minutes and two hours 20 minutes. All of these observations were signed off, as required by prison policy, by senior staff/managers and there is no evidence that any action was taken in response to the shortfalls. It was also found that, contrary to Prison Service policy, there were occasions when Frances' SPAR booklets did not move with her when she attended appointments off the landing. This undermines the role of the booklet in ensuring effective communication between all of those involved in the care of a vulnerable prisoner.

Whilst these failures are not considered to have contributed to Frances' death, it is clearly the case that such failures in the future could increase the likelihood of a serious incident or tragedy. The Prisoner Ombudsman has made recommendations in connection with similar failures on several previous occasions and the Prison Service and South Eastern Health and Social Care Trust have made efforts to address the concerns raised. It is, however, clearly the case that implementation of the recommendations is not always being consistently achieved.

In considering regime and healthcare issues that impacted on Frances' wellbeing it is to note that, contrary to recommendations made by Professor McClelland in his 2005 publication, *'A review of Non–natural Deaths in Northern Ireland Prison Service Establishments (June 2002 – March 2004)'*, which were also repeated several times by the Prisoner Ombudsman, a care co-ordinator and/or adequate care management arrangements were not in place to comprehensively co-ordinate, monitor and evaluate the delivery of an appropriate package of regime and healthcare intervention for Frances.

Putting in place a mechanism for ensuring the timely delivery of a package of appropriate interventions, evaluating the efficacy of such interventions and ensuring that changes in the care/management plan can occur in a timely manner is challenging. This is particularly the case in a custodial setting where the Prison Service, the South Eastern Health and Social Care Trust and other partners have responsibility for different care strata. It is, however, of fundamental importance if tragedies are to be avoided.

As noted in the Preface to this report it was also suggested to the Prisoner Ombudsman during the course of the investigation, that some inmates had treated Frances in a way that could be described as bullying and that this might have contributed to her death. The bullying was said to be as a result of inmates believing that Frances had told the security department at Hydebank Wood that she had seen a male prison officer kissing a female inmate.

The investigation did find evidence that Frances was treated in a way that could be described as bullying by some inmates. Whilst it is not possible to say what impact this had on Frances' already fragile mental health, an examination of all the related evidence suggests that it is unlikely that bullying by other inmates was a direct cause of her death at the time when it occurred. The evidence examined and action taken in connection with this matter is described in Section 15.

The investigation also identified some concerns about how staff involved in finding and trying to assist Frances, were supported. These are described in Section 14.

The South Eastern Health and Social Care Trust (SEHSCT) and Prison Service responses to the Issues of Concern detailed in this report are included at Section 18.

Amongst other observations, the SEHSCT's response raises the matter of the appropriateness of locating someone with Frances' complex care needs in a custodial setting. The Trust recognised that, if no viable alternatives can be provided, the issue of what care/management strategies need to be provided and co-ordinated to avoid future tragedies, must be addressed.

Clearly the answer to these questions has implications for both the Criminal Justice system and healthcare provision.

## ISSUES OF CONCERN REQUIRING ACTION

The following are issues of concern, identified during the investigation into the death of Frances McKeown, which require action by the Northern Ireland Prison Service (NIPS) and South Eastern Health and Social Care Trust (SEHSCT.) I have asked the Director General of NIPS and Chief Executive of SEHSCT to confirm that these issues will be addressed, where relevant service wide.

1. The SPAR process

   i. Case review summaries were seen to not include details of what was discussed and how/why actions were agreed.
   ii. Some observation logs, which had been quality checked by management, were not being completed as required by the care plan and, in particular, observations were not carried out at the required intervals. No evidence was seen to indicate that, where this occurred, the shortfalls were discussed and addressed. This has previously been raised by the Prisoner Ombudsman in connection with a number of other Death in Custody investigations.
   iii. SPAR booklets were found, on occasions, not to remain with Frances when she attended appointments or activities away from the landing.
   iv. No evidence was found that Frances' SPARs were reviewed to establish whether there was a pattern to her self harming or whether there were triggers for episodes of low mood which should be considered as part of her care plan.

2. It was five and a half months before Frances was considered by Hydebank Wood's Safer Custody Team.

3. The 'code blue' alarm set off in Hydebank Wood Young Offenders Centre on the night of Frances' death was announced in Hydebank Wood Women's Prison and resulted in an automatic lock down. Consideration should be given to whether alarms in one prison, and in particular 'code blues', should be announced / result in lock downs, in the other.

4. Frances' police custody records were not recorded by prison healthcare as being received on committal and there is no evidence that they were considered by prison and healthcare staff. The Prisoner Ombudsman has previously drawn the attention of management at Hydebank Wood to the need for full consideration to be given to police custody records.

5. A psychiatric referral on 8 November 2010 was not actioned and the systems in place did not flag up this failure.

6. There was a lack of clarity around the target timescales for referrals to mental health services and psychiatric services to be actioned.

7. Frances' difficulty sleeping was not adequately addressed.

8. Although Frances had a known history of psychiatric hospitalisation and was on psychotropic[10] medication, her GP and hospital medical notes were not requested.

9. Although Frances had a known history of psychiatric hospitalisation, was on psychotropic drugs and self harmed and threatened suicide whilst in prison, it was more than six months before she saw a psychiatrist.

10. When Frances eventually saw a psychiatrist, her assessment was limited because her GP and hospital records were not available to the psychiatrist.

11. Antipsychotic medication was prescribed without a face to face GP review.

12. Frances was not adequately monitored for possible worsening of psychotic symptoms when she was given an antidepressant (Fluoxetine) when she was already prescribed the antipsychotic Risperidone.

13. Frances was able to abuse her medication and access non-prescribed antidepressant medication (Trazodone).

[10] Psychotropic medication acts primarily upon the central nervous system where it affects brain function, resulting in alterations in perception, mood, consciousness, cognition and behaviour.

14. Nursing staff said that medical response bags contain too much equipment, some of which is not necessary.

15. The need for the use of Control and Restraint procedures, to relocate Frances to an observation room might have been avoided.

16. Staffing arrangements over Christmas, Easter and other Bank Holidays result in longer lock-downs and less access to purposeful activity and work for vulnerable prisoners. The fact that ID cards are not routinely removed from empty rooms led to confusion about whether or not Frances was in her room.

17. A care co-ordinator/ adequate care management arrangements were not in place to comprehensively co-ordinate monitor and evaluate the delivery of an appropriate package of regime and healthcare intervention for Frances.

18. Prison staff said that they felt that the support available to them after Frances' death was not adequate.

# INTRODUCTION TO THE INVESTIGATION

## Responsibility

1. As Prisoner Ombudsman[11] for Northern Ireland, I have responsibility for investigating the death of Mrs Frances McKeown. My Terms of Reference for investigating deaths in prison custody in Northern Ireland are attached at Appendix 1 to this report.

2. My investigation as Prisoner Ombudsman provides enhanced transparency to the investigative process following any death in prison custody and contributes to the investigative obligation under Article 2 of the European Convention on Human Rights.

3. I am independent of the Prison Service, as are my investigators. As required by law the Police Service of Northern Ireland continues to be notified of all deaths in prison.

## Objectives

4. The objectives for the investigation into Frances' death were:

- to establish the circumstances and events surrounding her death, including the care provided by the Prison Service;

- to examine any relevant healthcare issues and assess clinical care afforded by the Prison Service and South Eastern Health and Social Care Trust;

- to examine whether any change in Prison Service or South Eastern Health and Social Care Trust operational methods, policy, practice or management arrangements could help prevent a similar death in the future;

[11] The Prisoner Ombudsman took over the investigations of deaths in prison custody in Northern Ireland from 1 September 2005.

- to ensure that Frances' family have an opportunity to raise any concerns that they may have and that these are taken into account in the investigation; and

- to assist the Coroner's inquest in achieving fulfilment of the investigative obligation arising under article 2 of the European Convention on Human Rights, by ensuring as far as possible that the full facts are brought to light and any relevant failing is exposed, any commendable action or practice is identified, and any lessons from the death are learned.

**Family Liaison**

5. An important aspect of the role of Prisoner Ombudsman dealing with any death in custody is to liaise with the family.

6. It is important for the investigation to learn more about an inmate who dies in prison custody from family members and to listen to any questions or concerns they may have.

7. I first met with Frances' husband on 8 June 2011 and my investigators were grateful for the opportunity to provide him with updates on the progress of the investigation. On 20 November 2012, I met with Frances' husband to explain and discuss the findings and recommendations within this report.

8. I also met with Frances' mother and father on 2 September 2011 and again on 20 November 2012 to explain and discuss the findings and recommendations within this report.

9. It was important for the investigation to learn more about Frances' background, history and personal circumstances before she died. I would like to thank Frances' family for giving me the opportunity to talk with them about this.

10. Although the report will inform many interested parties, it is written primarily with Frances' family in mind. It is also written in the trust that it will inform policy or practice, which may help to prevent a similar death in the future at

Hydebank Wood Women's Prison or any other Northern Ireland Prison Establishment.

11. The following questions were raised by Frances' husband:

- Taking into account Frances' mental health condition, as detailed in her community medical records, why wasn't she looked after properly in Hydebank Wood Prison?

- Given that Frances was a vulnerable person, why was she allowed to have a bathrobe tie in her room?

- Why wasn't Frances observed more frequently, considering her mental health condition?

- Why was there a delay of over two hours when notifying Mr McKeown of his wife's death?

# FINDINGS

## SECTION 1: BACKGROUND INFORMATION

Mrs Frances McKeown was 23 years old when she died on 4 May 2011, whilst in the custody of Hydebank Wood Women's Prison.

When Frances was about 13 years old her family said that they noticed changes in her mood and personality traits. Frances also started to self harm and, as a result, she started to attend community mental health services.

Frances' family said that, throughout her school years, Frances was bullied *"quite badly"*, but after leaving school, she attended Newry Technical College and achieved a diploma in child care and had a part-time job.

At 18 years old, Frances' family stated that she *"drifted away"* from them and she stopped engaging with community mental health services. At 19 she met her husband and had their first child. Following the birth of their child and difficulties with their marriage, Frances and her daughter moved away from the family home. After the birth of Frances' second child, she experienced further difficulties and both children were taken into care.

After Frances' children were taken into care, and following her making an allegation that she had been the victim of a sexual assault, Frances' mental health deteriorated and as a result she was admitted to Craigavon's Bluestone Mental Health Unit. Frances was subsequently admitted to Bluestone on a further ten occasions. It was during these admissions that Frances was diagnosed with Emotionally Unstable Personality Disorder. Frances' family said that Frances also suffered from post natal depression after the birth of her second child and said that there was a period of 12 months when Frances did not see her children.

Frances' GP records note that in the 12 months prior to her committal to Hydebank Wood Prison, she had low mood, had taken a number of deliberate overdoses

(Paracetamol) and had inflicted self lacerations. She was again under the care of a community mental health team.

As part of the investigation, an independent clinical review was carried out by Dr Seena Fazel, Consultant Forensic Psychiatrist at Oxford University, on the medical and health care of Frances, whilst she was in Hydebank Wood Prison. In his review report he stated: *"on the basis of the background history, Ms McKeown has a number of risk factors that indicate that she has an increased risk of suicide in custody. These include a history of recent suicidal thoughts and attempted suicide before custody…..a current psychiatric diagnosis, and historic reported sexual abuse – all of which are risk factors for suicide in custody."*

## SECTION 2: FRANCES' FIRST WEEK IN HYDEBANK WOOD PRISON - 22 TO 29 SEPTEMBER 2010

### 22 September 2010

On 22 September 2010, Frances was remanded into the custody of Hydebank Wood Prison having been charged with a number of offences. This was the first time that Frances had been in prison. At the time of Frances' arrest it was recorded in her police records that, *"DP [detained person] appears to be suffering from mental health issues and stated she is feeling suicidal…..DP is calm at present and co-operative with Police although has stated that not a lot has changed since she last attempted to cut her throat."*

On the Prisoner Escort Record, which is handed over during transfer from police to prison custody, it is recorded that Frances suffered from *"depression and anxiety. Attempted self-harm 6-8 weeks ago. States currently feeling suicidal."*

On committal to Hydebank Wood Prison, Frances was interviewed by a prison officer, a nurse and a residential manager. The prison officer recorded that Frances had attempted suicide six weeks previously but had no current thoughts of self harm. This was at odds with the information recorded on the Prisoner Escort Record. The officer also recorded that Frances had a history of illegal drug and alcohol misuse and was reported to have used methadone more than a month prior to her committal. She said that she had no immediate needs that required attention and her disposition was recorded to be *"cheerful"* and *"co-operative".*

During the healthcare screening process, the nurse recorded on EMIS[12] that Frances' behaviour was appropriate and that she was communicative throughout; she expressed no worries or concerns; she had a history of psychiatric hospitalisation and self harm – although none currently - and was taking Risperidone[13] 4mg daily prior to her committal. There is no evidence to suggest that the staff involved in Frances' committal received or considered the Prisoner Escort Record.

[12] EMIS – Egton Medical Information System – an electronic medical records system used by the healthcare department of the Northern Ireland Prison Service.
[13] Risperidone – an oral medication that is used as a major tranquilizer or antipsychotic.

**23 and 24 September 2010**

Over the following two days, as part of the committal process, Frances was seen by Probation, Psychology, Opportunity Youth[14] and had a family visit. A nurse officer also contacted Frances' GP and confirmed that her medication was Risperidone 4mg but did not request her medical records. A medication review was then completed by a prison doctor. Frances was not present when the doctor carried out this review, but was prescribed the same medication that she had been receiving in the community. At interview, the doctor stated that it was common in primary care to repeat prescriptions without seeing an individual.

The first time that Frances was seen by the prison doctor was on 1 October 2010.

Commenting on Frances' committal, the clinical reviewer, Dr Fazel, stated that: *"I note that on committal, her GP was phoned and the correct dose of her Risperidone was given. This is good practice."* However, Dr Fazel noted that Frances' GP medical records were not requested at that point, or following the prison doctor's medication review. Dr Fazel also said that as the prison represents a new environment and the first weeks in custody are known to be a difficult time, particularly for first-time entrants, he thought that an early face to face direct medical assessment is very important where antipsychotic medication is prescribed.

**25 to 28 September 2010**

On 25 September, concerned that Frances wasn't settling well in prison, an officer on Frances' landing requested that Frances be seen by Opportunity Youth for crisis intervention support. Frances was seen by a member of Opportunity Youth on 25, 26 and 27 September.

A record of the initial meeting with Frances notes the following:

*"Frances presented in good form. Not in a good place. Does not like being locked up. Could not guarantee that she would not cut - after talking this through with Frances a*

[14] Opportunity Youth provide a comprehensive range of personal development and therapeutic services, including three one to one intervention sessions for those inmates who are finding it difficult within their first week of prison.

*verbal agreement was made between Frances and (Opportunity Youth worker) that she would not cut and that one to one support would commence. Frances confirmed that she was feeling ok at this stage. At the end of the meeting Frances was confident that she would be able to remain safe."*

The following day, the Opportunity Youth worker contacted Frances' landing and was advised that she had requested a further one to one session. The following was recorded in her Opportunity Youth notes:

*"Frances felt that she was unable to refrain from cutting mainly due to being annoyed with another inmate. Alternatives to cutting discussed and discussed with the officer on duty. Frances felt confident she could keep herself safe.*

*Follow Up Action*

- *Frances to use lock up time to read and do artwork to keep occupied.*
- *Officer to speak to other inmate to ask for distance to be kept.*
- *Officer to ensure that Frances and other inmate are not together during 'split association'.*
- *Opportunity Youth are to meet with Frances tomorrow and review."*

The following day, 27 September 2010, Opportunity Youth met with Frances and noted that she had had a good afternoon (on the previous day) and a good morning. She had no thoughts of self harm or suicide and was keen to continue engaging with Opportunity Youth.

On 27 September, Frances was also triaged by a nurse because she said that she had not been sleeping well since her committal. It is recorded on EMIS that the plan was for Frances to be seen by the prison doctor to discuss her sleeping problem further. At interview, the nurse said that she fully expected Frances to be seen by the doctor when the doctor was next in the prison. The next day another nurse recorded on EMIS that Frances would require a mental health assessment prior to seeing the prison doctor for her sleeping problems and a referral to mental health was completed. Due to her long term absence from work, it was not possible to interview the nurse who completed the mental health referral and ask her why she determined that Frances should not see the doctor as planned. However, Frances' mental health nurse

said that the reason why a mental health assessment was requested was because of the high currency value of sleeping tablets within the prison. The nurse said that it is the role of the mental health nurse to ascertain if there are sleep hygiene factors that should be addressed, prior to considering a prescription for medication.

It is to note that, following the referral on 28 September, Frances was not seen by the mental health nurse until 8 November 2010. This is discussed further in Section 4.

## SECTION 3: SPAR BOOKLET 29 SEPTEMBER TO 5 OCTOBER 2010

On 29 September, Frances cut both of her arms. A SPAR booklet[15] was opened and it is recorded that the reason Frances cut herself was due to *"other problems"* but that the catalyst for cutting was the stress of an ex-boyfriend being murdered three weeks previously. It was also recorded that Frances had, in the past, *"attempted suicide approximately seven times although this is under control at present,"* and that it was quite clear that she did not want to die due to her many reasons for living (details of which were not recorded).

The 'Immediate Keep Safe' action plan recommended that Frances should, following a search for any sharp objects which could be used to cause further harm, remain in her own room and be observed at intervals of no more than 30 minutes.

On 30 September, an initial case review was carried out which was attended by Frances. The record of the review notes that *"Frances attended and states that she had no thoughts of self harm (cutting) or suicidal thoughts at the moment. But, Frances could not guarantee her safety or that she would not cut again. All in agreement SPAR to remain open."* The action plan for Frances was also updated to include a referral to the mental health team and to Cruse for bereavement counselling. The nurse officer, who attended the case review, subsequently recorded on EMIS that Frances' referral to Cruse had been actioned and that she had contacted a mental health nurse to arrange a mental health assessment *"and was informed that a MHS (mental health support) referral had already been placed on the 28 September 2010…"* in connection with Frances' sleep problems.

### Consultation with Prison Doctor

On 1 October, Frances was seen by a prison doctor. The doctor recorded that Frances had no thoughts of self harm at that time and that *"fairly recently, self harm thoughts are less frequent."* The doctor noted that Frances had been admitted to Craigavon's Mental Health Unit on 11 occasions and had two infants in foster care. She noted also that Frances was complaining of insomnia.

[15] Supporting Prisoners at Risk (SPAR) booklets are used at times when staff deem an inmate as vulnerable to self harm and suicide to provide increased observations and support for inmate.

As Frances had not yet been assessed by the mental health team, the doctor was asked at interview what action she took in response to Frances' insomnia. The doctor said that *"it would be hard to sleep coming into prison anyway regardless. Sometimes we give people sleeping tablets for a few days but there's a lot goes on, on the landing….there are some veterans who will bully a new prisoner to get their medicines. So these [sleeping tablets] would be great currency tablets."* Asked why Frances didn't receive any sleeping tablets or assistance with her sleep hygiene, the doctor said that was *"because we [Frances and the doctor] must have agreed that, you know… it's hard for anybody to sleep in prison."*

The prison doctor was also asked why, when Frances disclosed to her that she had been a psychiatric inpatient on 11 occasions, this did not trigger a psychiatric referral. The doctor said that she would not refer directly to the prison psychiatrist, but would instead refer to the mental health team. The investigation established that it was normal practice at Hydebank Wood that all psychiatric referrals must go through the mental health team.

Commenting on the doctor's consultation, the clinical reviewer Dr Fazel said that *"The prison doctor (name redacted) reviewed Ms McKeown and was told by her that she had been a psychiatric inpatient on 11 occasions. This could have led to a referral for an assessment by a psychiatrist, although [the prison doctor] may have been aware that Ms McKeown was on the waiting list to be seen by a mental health nurse….[however] the notion that a GP in a prison cannot refer directly to a psychiatrist seems overtly restricted in my view. It would be appropriate to do so, particularly if mental health nurses were not available for discussion or if there was a difference of opinion on whether a referral was appropriate."*

On 5 October, a further case review took place and all in attendance agreed that whilst Frances cut herself for relief *"she had absolutely no thoughts of self harm."* As a result, it was agreed that the SPAR booklet could be closed.

**SPAR Observation Logs**

A review of the logs detailing observation of Frances during the period that this SPAR was open show that, despite the 'Immediate Keep Safe' action plan recommendation

that she should be observed at intervals of no more than 30 minutes, there is evidence that on three occasions Frances was observed after intervals of about 45 minutes, on one occasion after an interval of around 50 minutes and, on 12 occasions, after intervals of approximately one hour. There are also single instances of observations only taking place after one hour 15 minutes, one hour 30 minutes and two hours 30 minutes.

There is no evidence of any decision to reduce the frequency of observation of Frances and all the recorded observations were signed off by residential managers**,** with no indication on the paperwork that any action was taken in response to these observation failures.

The Prisoner Ombudsman has previously made recommendations as a result of similar failures, in the context of a number of Death in Custody and complaint investigations.

**Ineligible Prisoner Ombudsman Complaint**

At some point during Frances' time on this SPAR she wrote to the Prisoner Ombudsman's Office complaining about her healthcare. Her complaint was received on 6 October. Frances wrote on the complaint form, *"Medical Department is deplorable."* In the section which provides inmates with the opportunity to indicate what they think should be done to put things right, Frances wrote, *"Listen more to inmates and help them. Don't palm them off."*

Since April 2008, responsibility for the investigation of complaints related to medical care in prison transferred to the South Eastern Health and Social Care Trust and the Northern Ireland Commissioner for Complaints. Frances was, therefore, contacted and advised how she could make a complaint to the Trust. The Trust has confirmed that no formal complaints were received.

## SECTION 4: KEY EVENTS BETWEEN 7 OCTOBER AND 9 NOVEMBER 2010

### 7 to 14 October 2010

Between 7 and 14 October 2010, Frances attended family visits, art therapy, the gym, education classes and Cruse bereavement counselling. She also had a follow-up meeting with Opportunity Youth following which it was recorded that *"Frances said she is doing well, working with Cruse. We discussed her feelings about missing her partner and how she was dealing with them. Frances and I feel no more brief interventions required at present. Follow Up Action – Frances said she will contact us if she needs us."*

### Self Harming Incident - 15 October 2010

On 15 October, Frances was triaged by a nurse. It is recorded in her medical records that *"Frances presented with very superficial scratches to right arm. When questioned why she had self harmed she did not wish to elaborate – reassurance given and accepting of same. Advised to contact healthcare should self harming thoughts continue. Further, Frances stated that she had no thoughts of life not worth living or suicidal ideations stating that it was just a release."*

When asked at interview why this instance of self harming did not result in consideration of a SPAR being opened, the nurse said that she couldn't recall this consultation and that she thought that the policy in Hydebank was that if someone has cut themselves you would open a SPAR unless *"there was no level of risk, you know, after that event.....If it was just a release and they've guaranteed me that they feel safe.....[and] the level of risk has significantly been eradicated as such....and she was giving me guarantees that she feels safe and there's no further thoughts of cutting, there probably wasn't a need for a SPAR."*

### 16 October to 7 November 2010

During this period, Frances had commenced regular work in the prison gardens and continued to have family visits and occasionally use the gym.

**Initial Mental Health Assessment – 8 November 2010**

On 28 September 2010, as stated previously, Frances was referred for a mental health assessment. On 30 September, as part of a SPAR review, a further request for a mental health assessment was made and was acknowledged by a mental health nurse. The mental health assessment took place on 8 November.

The mental health nurse who carried out the review was asked at interview why it took almost six weeks to arrange. The nurse said that the first time she attempted to assess Frances was on 3 November 2010, but she was unable to do so because Frances was at a church service. She said that it took as long as it did to assess Frances because she (the nurse) had not been allocated to carry out mental health work during that time. She said that mental health was not *"ring fenced",* which meant that mental health reviews could be affected by other general nursing duties taking priority.

The nurse said that it was the responsibility of the healthcare manager to detail what type of work the nurses would carry out, on a day to day basis. She said, however, that where an urgent mental health assessment was required, and was brought to her attention by a colleague, she would approach her line manager to request the time to assess the individual that same day. The nurse said that Frances had not been brought to her attention as requiring an urgent mental health assessment.

It is to note that, in May 2011, after Frances' death, a full time mental health post was provided by the South Eastern Health and Social Care Trust for Hydebank Wood Women's Prison and Young Offenders Centre. The investigation has been advised that, as a result of this action, all mental health referrals at Hydebank Wood are now seen within 21 days.

At her mental health assessment, on 8 November 2010, Frances said that she had been a psychiatric patient 11 times previously, was currently an outpatient and had two infants in foster care. She disclosed a history of alleged childhood sexual abuse, domestic violence and self harm and explained that she felt better on Quetiapine 125mg (an antipsychotic drug) and Fluoxetine 40mg (an antidepressant.) The mental

health nurse recorded on EMIS that a referral to psychiatry would be required in order for Frances' medication to be reviewed.

The investigation found that the referral to the psychiatrist was not actioned and, at interview, the mental health nurse was shocked to hear this stating, *"if I've written it down, I'll have done it. Definitely."* The investigation established that the referral, whilst recorded on EMIS, had not, as required, been noted in the healthcare centre's Psychiatrist Referral Book.

On the day following Frances' mental health assessment, the prison doctor prescribed the antidepressant Fluoxetine for her. This was in addition to the Risperidone that she was already taking. Although Frances had said that she felt better when taking Quetiapine (an antipsychotic medicine), the doctor said at interview that she would not issue a new prescription without a psychiatrist first considering whether Frances needed it. The doctor said that this would be consistent with her practice when caring for patients in the community.

Commenting on this, Dr Fazel said in his clinical review report that *"I do not think it is appropriate that a qualified doctor working in primary care cannot prescribe one particular antipsychotic. If this is the case, then further training would be appropriate."*

**Self Harm Incident – Nurse Review on 9 November 2010**

On 9 November, Frances was seen by a nurse who recorded that *"inmate feels it is hard to cope without cutting, at present. She is picking at old scabs on her arm and she has abrasions on her forearms where she has been rubbing at them with a pen. She says the pressure on her landing due to inmates coming off illegal drugs is wearing her down. We have had a long talk about coping, not sure it will work. She states she has no suicidal thoughts and only cuts to cope. House senior officer has been made aware of the situation, and will alert night time staff."*

Although the nurse recorded being uncertain about whether or not the talk he had with Frances would *"work"* in preventing her from self-harming, a SPAR booklet was not opened by the nurse or by the senior officer with whom the nurse spoke.

## SECTION 5: SPAR BOOKLET 13 TO 26 NOVEMBER 2010

Four days after scratching her arms, a SPAR booklet was opened on 13 November 2010, due to Frances saying that she had thoughts of suicide.

The officer who initiated the opening of the SPAR recorded *"I have had several conversations with Frances over the last few days and I know she has been getting it tight so to speak…..I now, after speaking with her tonight, believe she is really at risk and I feel her safety now, as always, is paramount. I know she is due for counselling soon but she said in conversation that she couldn't last until then – that she might not last the night."*

Frances was due to start NEXUS[16] counselling two days later to help her to address some of the difficulties connected with her past.

Following a case conference on 13 November, it is recorded on the 'Immediate Keep Safe' action/care plan (which is part of the SPAR booklet) that Frances could not guarantee her safety until the following morning and, as a result, the decision was made to move her to an observation room and observe her at 15 minute intervals. This was authorised by a governor in line with Prison Service policy.

The following day, Frances had a SPAR assessment interview with a senior officer. The senior officer recorded that Frances clearly had a suicide plan and had felt suicidal during the night. She noted that Frances *"gives me grave cause for concern as she is withdrawn,"* and still appeared to be at high risk of suicide because she was *"uncommunicative and morose…appears depressed and continued to voice negativity to all our suggestions."* A decision was taken to keep Frances in the observation room in order *"to keep her safe."* Frances' care plan was updated to include supervised access to her possessions in her room.

It is recorded that Frances recognised that her move to the observation room the previous night, meant that she could not carry out her suicide plan. At the case review on 14 November, she said that she didn't want to return to the observation

[16] The NEXUS Institute provides counselling and support to victims of sexual abuse.

room and that the only way staff would get her there was if they moved her *"forcefully"*. It is recorded that the nurse in attendance had a lengthy discussion with Frances to try to persuade her to go into the observation room but Frances walked out. Knowing that Frances had a good rapport with her mental health nurse, the nurse contacted the mental health nurse to see if she could resolve the situation and prevent Frances from being put in the observation room forcibly using Control and Restraint techniques.[17]

The mental health nurse spoke to Frances who recorded that she was *"tearful and emotionally upset….allowed to ventilate and expressed her feelings of depression."* The mental health nurse contacted the doctor and requested a prescription of Diazepam[18] for Frances which was agreed and issued to her. As a result of the mental health nurse's efforts, Frances agreed to move into the observation room and this was achieved without causing her further distress.

Further case reviews took place on 15, 16, and 19 November and it is noted that Frances steadily improved and was able to return to her own room and to be observed at 60 minute intervals. It is recorded on 19 November, that Frances said *"she feels safe with the booklet open and is not ready at present for it to be closed."* The SPAR booklet remained open until 26 November, when, at a case review attended by Frances, it was agreed that she was happy and content with no thoughts of suicide.

A review of the observation logs shows that observations were carried out at the required intervals and were comprehensive and Frances continued to engage in purposeful activity.

A SPAR post closure review with a senior officer, which was due to take place on 2 December, took place on 9 December, with Frances and a senior officer. A record of the review states that Frances had *"no issues at the moment."* At the time of this post closure review, however, Frances was already subject to another SPAR booklet (detailed in Section 6) to which no reference was made.

[17] Control & Restraint (C & R) techniques may only be used when verbal persuasive methods have failed, to protect persons or property, to prevent an escape or recapture an escapee or to overcome a threat to the good order of the establishment.

[18] Diazepam. A type of medicine called a benzodiazepine which is used for sedative, anxiety relieving and muscle relaxing effect.

## SECTION 6: OPENING OF FURTHER SPAR BOOKLET

On 27 November 2010, the day after Frances' last SPAR booklet was closed, she saw a nurse officer who recorded that she had *"low mood…feels depressed although not suicidal and has no thoughts of self harm. Allowed to ventilate and have agreed to ask* (her mental health nurse) *to see her and* ? (question) *recommend increasing her antidepressant. Frances was happy with this."*

The investigation found that Frances' medication was not reviewed and she did not see her mental health nurse again until 6 December.

Over the next few days, Frances continued to attend her work in the prison gardens but on 1, 3, 4, and 5 December she was complaining of headaches and was given Paracetamol by healthcare staff on each day.

On 5 December, nine days after the closure of Frances' last SPAR booklet, she reported that she had taken an overdose of 42 Paracetamol tablets. A new SPAR booklet was opened and she was taken to outside hospital.

The nurse who attended to Frances recorded *"Inmate was witnessed* [by another inmate] *taking a handful of drugs tonight after she had a bad phone call. Inmate refusing to talk to me or let me do observation, she eventually admitted to taking 42 Paracetamol which she said she had been saving up for a long period. She has agreed to go to A&E for blood test; she will not discuss her reason for overdose and is very angry at staff. Escort arranged to take inmate to A&E. I had inmates room searched and found only 12 empty Paracetamol cases in her room bin. Inmate is on daily medication issue and she has been complaining of headache on a constant in the morning. SPAR opened."*

The SPAR booklet notes that the *"bad phone call"* Frances received was in relation to the ill health of a family member and that she said that *"we* (staff) *didn't care and she wanted to die."*

It is recorded that, whilst at outside hospital, Frances refused to have blood tests but suffered no apparent ill-effects from her reported overdose.

Following Frances' return to prison, it is recorded on her 'Immediate Keep Safe' action/care plan that she was to be placed on 30 minute observations and located in her own room. Frances was also placed on supervised swallow of her prescribed medication. A mental health nurse recorded that Frances *"appeared more settled"* and regretted her actions. The nurse also recorded that Frances *"denies any thoughts of self harm or suicide intention at present."*

On 8 December 2010, a case review was held and it was noted that Frances was hoping to get bail on 13 December. The record of the case review also noted that Frances *"is very impulsive and states that she has no thoughts of self harm or suicide however she will not show any indications if she is going to hurt herself. This SPAR will remain open to see how the bail goes. If she does not get bail this may have an adverse affect on her."* Frances' care plan was updated to include continued support from mental health and counselling sessions with NEXUS.

Frances did not get bail as she had hoped.

On 14 December, it was agreed by those attending a further case review that Frances' SPAR booklet could be closed. A summary of the review and the reasons for this decision were not, however, documented.

A review of Frances' observation logs during the period this SPAR was open shows that they were completed in accordance with her care plans, that she had regular interaction with staff and that she engaged in purposeful activity.

## SECTION 7: EVENTS BETWEEN 15 DECEMBER 2010 AND 3 MARCH 2011

Between the closure of Frances' SPAR booklet on 14 December and the opening of a further SPAR booklet, her fourth, on 4 March 2011, a review of Frances's records suggest that she continued to be involved in some activity most days (Monday to Friday) working in the gardens or attending art, crafts, reading and hairdressing classes, family visits and NEXUS counselling sessions.

### NEXUS Counselling Sessions

Notes made by Frances' counsellor over six sessions between 10 January and 14 February include the following comments:

- *"Talks about putting everything behind a door and too afraid to open it."*
- *"Client looked well today, had hair cut, looked content and said she felt happier…feels she's coping quite well."*
- *"Afraid of her inner feelings…wants to rely on herself and no one else. Does not like who she is."*
- *"Much more relaxed today – makeup on and looked well….explored what she would like to happen when she's released – back to work, get kids back, not bothered about another relationship."*
- *Seems to be looking forward to the future and thinking of her kids….Self-harm – 'has not done as much' – feels maybe she is starting to cope a bit better."*

### Medication Spot Check – 14 February 2011

On 14 February 2011, a medication spot check was carried out on Frances. She had been issued with a week's supply of medication on 12 February and when she was requested to produce the medication that she should have had in her possession, it is recorded that she had none. It is also recorded that Frances could not account for where her medication had gone. She said that this was because she had left her room door open. The doctor, who was present when Frances was questioned about her missing medication, made the decision to stop all of Frances' medication until she could be assessed by a mental health nurse. The doctor recorded *"drug Rx* (prescription) *stopped – medical advice, tablets have gone missing from her cell??*

*Where?? Needs them?? Therefore STOP until mental health review"*. A mental health referral form was completed which recorded the reason for referral.

Asked about her decision to stop Frances' medication, the doctor said at interview that because Frances couldn't explain where her tablets were, she thought *"If I didn't know where the tablets were going wouldn't it be better that she didn't have any tablets than somebody coming up [and bullying her for them]"*. Discussing the alternative options available to the doctor, such as placing Frances on daily supervised swallow of her tablets, the doctor said *"the nurses organise all of that. And sometimes the women don't like that. How they give out the tablets is the nurses' decision."*

It is, however, the case that, in the absence of a doctor's prescription, the nurses would be unable to give medication to Frances and could not, therefore, consider administering it in a different way.

The doctor also stated that she expected Frances to be seen by mental health within a couple of days. In the event, Frances was not seen by mental health until 4 March 2011 and was, therefore, without antipsychotic and antidepressant medication for 19 days.

Commenting on the doctor's decision to stop Frances' medication, the clinical reviewer, Dr Fazel said that this was *"not appropriate"* and *"there is no clear rationale for this." "There are",* he said, *"a number of questions raised by this course of action. First, Ms McKeown's explanation for the missing medication is not recorded. Second, although the prison doctor stopped her medication, she requested a mental health review but this did not occur for a further three weeks. The prison doctor did not appear to chase this up. Third, on stopping her medication, the prison doctor writes 'needs them???' which seems to contradict her psychiatric history (which suggests that she has been prescribed these medications for many years by specialists). Fourth, such a course of action could have been discussed with the prison psychiatrist. Fifth, I am not aware of Risperidone being used in this way, as it is not a drug of abuse in the community. Finally, an alternative was not apparently discussed with Ms McKeown of having to take her medication in front of staff or having it daily in possession.…It is notable that the prison doctors next meeting with Ms McKeown is recorded as a consequence of low mood and suicidal ideation, suggesting a deterioration in her mental state."*

On 2 March, it is recorded that landing staff notified a nurse that they were concerned about Frances' mood being low. The nurse recorded on EMIS that Frances had still not had a mental health review and requested the doctor see her and recommence the antidepressant which the doctor had previously stopped.

On 3 March, landing staff recorded that Frances was *"upset, tearful and feels her head is going….she feels she can hear voices and wants to go back to her old ways of cutting her arms."* It is also recorded that this was reported to the senior officer and a nurse who went and spoke to Frances. The nurse also recorded that Frances was *"tearful"*, that a police interview she'd had that morning had upset her and that she was seeing her solicitor that afternoon about her children's custody arrangements. The nurse recorded that at the time of leaving her, Frances had settled.

**Telephone Calls**

Between 8 February 2011 (the earliest date for which calls were available on the Prison Service calls recording system at the time of Frances' death) and 3 March, Frances made 16 telephone calls to her family and friends. Frances discussed her relationship with her parents and husband, the ongoing legal matters relating to the custody of her children, family visits and letters.

The only time that Frances spoke of her mental health during phone calls was on 28 February. On this date, Frances made three calls to her husband at 11.53, 17.18 and 19.21. During the conversation at 17.18, Frances told her husband that she was no longer taking any medication and that she felt better off her tablets than she did on them. Her husband replied that she needed to "*make sure it doesn't creep round the corner and bite you again.*" Frances told him that she was aware of this and now has control and "*it won't happen again."* In the phone call at 19.21, Frances told her husband that she felt *"depressed".*

## SECTION 8: SPAR BOOKLET - 4 MARCH TO 1 APRIL 2011

On 4 March, Frances saw the doctor who recorded she had low mood and thoughts of suicide. The doctor also recorded that she'd sought advice two weeks ago regarding Frances' medication and that *"hopefully she'll be seen by mental health this afternoon."* She wrote that Frances was *"angry with herself and all around her"* and that she said she had not missed her medication *"as they were useless."* A SPAR booklet was opened but no medication was prescribed by the doctor.

The 'Immediate Keep Safe' action/care plan completed at this time notes that Frances was to be placed in an empty room with her own clothes and bedding and to be observed at intervals of no more than 30 minutes.

The initial assessment of Frances notes how the voices she had been hearing were constant and that when she thinks about suicide her thoughts are *"nasty"*. That afternoon, Frances' mental health nurse assessed her and requested, via the doctor, that she be prescribed Diazepam until her medication could be recommenced the following day.

On 5 March, and on the recommendation of the mental health nurse, the doctor prescribed the antipsychotic and antidepressant medication for Frances which she had previously stopped. It was agreed for Frances' own safety and that of others that she would be moved to the healthcare centre *"to give her time to re-coup her thoughts and re-adjust her thinking."* It was noted that *"Frances is in a really bad place at present. She has stated that she will kill someone, maybe even herself"*. It was also noted that Frances had said that *"smiling at staff and appearing upbeat had fooled staff."* In response to Frances' feelings of anger, a referral was made to Opportunity Youth.

### SPAR Case Reviews

SPAR case reviews took place on 8, 11, 13, and 15 March.

On 11 March, it was noted that Frances was progressing well in the healthcare centre and was to have a phased return to normal location. This involved her returning to

her landing during the day and sleeping in the healthcare centre at night. At the review on 13 March, it is recorded that Frances was apprehensive about moving back to Ash House but that she agreed to give it a go. On 15 March, it is noted that whilst Frances appeared settled back in Ash House, at the review she was angry and unsettled and had said she was *"still feeling angry enough to hit someone"*. Frances' care plan was updated to include a referral to an anger management programme, to Cognitive Behavioural Therapy and to the Hydebank Wood's Safer Custody Team.

On 20 March, a further case review was convened. Frances had written a letter which clearly indicated that her plan for suicide was *"imminent and live"*.

In the letter Frances talked about her "*normal problems*" which she listed as relating to her childhood, family, marriage, kids and the murder of a previous boyfriend. She went on to say:

*"My problems are now things I haven't suffered from since I was about fifteen. It's the thoughts I'm having and the voices I'm hearing. I have non stop thoughts about seriously hurting people and even killing people. I think everything out to the finest detail of what I would do, and I don't care if I get caught, I just want to hurt people including myself.*

*The voices in my head are getting worse and more violent, they run me down and make me so angry. It's like I'm sitting on my own but there is someone in the room with me telling me what to do and to hurt people and I have to fight it's so hard, not to try and listen to it. At night when I am in my cell it is worst because I can't distract myself from it all I can do is listen to it and the horrific things it tells me to do.*

*Hell everyday of my life and if I am dead it would all be over for me and I wouldn't have to suffer anymore because I can't put up with it any longer.*

*You're evil/your scum*
*You deserve to be dead*
*You should have been killed when you were born*
*You're a mistake*
*You know I'm rite*

*Stick to the plan I'll tell you when*
*You're pathetic*
*You know you're going to hang yourself*
*You're going to kill them I'll make sure you do*

*I can't do it anymore, I'm done trying, I just want to die and end it all. I can't put up with it anymore. It's too hard and too tiring.*

*JUST LET ME DIE!!!"*

The nurse who attended the case review on 20 March recorded on EMIS that she referred Frances to psychiatry because she was *"very worried about Frances"* and felt that she needed to be seen as soon as possible. (It is to note that the need for a referral to psychiatry was first recorded on EMIS on 8 November 2011, following Frances' first assessment by a mental health nurse. This referral was never actioned.)

**Move to an Observation Room**

It was agreed at the case review that in order to keep her safe, Frances would be moved to the observation room on Ash 4. Frances categorically stated that she would not move willingly and as a result she was forcibly put into the observation room using Control and Restraint techniques. There is no recorded evidence that, as required by Prison Service policy, other means of persuasion, such as asking Frances' mental health nurse to talk to her or requesting healthcare to issue her with Diazepam (as was the case on 14 November when Frances had similarly refused to move to an observation room), were considered or carried out.

It is to note that, following a number of complaint investigations, the Prisoner Ombudsman has raised significant concerns with management at Hydebank Wood about the manner in which Control and Restraint techniques are, at times, used to move vulnerable prisoners. As a result of these concerns and recommendations, a review is currently being carried out.

On 22 March 2011, it is recorded that Frances was returned to normal location *"because she is not as angry as she was at the weekend"* and had given reassurances

that she would not act on her suicide plan. The main concern noted was that Frances was still *"hearing voices in her head".* As Frances was due to attend court in two days time and would not confirm that she would not self harm, the escorting staff were told to observe her at 15 minute intervals during her court attendance.

**Therapeutic Inputs**

Frances commenced Cognitive Behavioural Therapy [CBT] on 22 March 2011. On 25 March, a further SPAR case review took place and it was noted that Frances had learned how to cope better over the past few days and that CBT was helping. A further review was scheduled for a week's time with a view to closing the SPAR booklet and all of Frances' possessions being returned to her.

It is recorded on Frances' EMIS records, that the psychiatrist spoke to Frances' mental health nurse on 25 March and it was agreed that Frances' community psychiatric notes should be requested and that she would be assessed after the psychiatrist returned from a period of leave. The psychiatric assessment took place on 12 April. This was more than six months after Frances was committed to Hydebank Wood and five months after a mental health nurse first identified the need for a referral.

On 29 March, Frances began to engage in further one to one sessions with Opportunity Youth as well as continuing to attend CBT.

**Further SPAR Review**

On 1 April, Frances had a *"bad visit"* with her mother and father. They said that they believed that this was because Frances had been told by her solicitor that she would receive a sentence of four to five years, when she had initially expected one year.

A further SPAR case review took place that day and all in attendance agreed that *"although she [Frances] had a bad visit with her [family] she was confident that she can cope and foresaw no danger of relapse. She is still engaging with CBT and is confident that she can approach staff should she feel the need."* It was agreed that the SPAR booklet could be closed.

A review of the observation logs for the period of this SPAR, shows evidence of comprehensive entries; consideration of sharing her room with another inmate for short periods *"to help keep her safe"* and entries during the day often being made at more frequent intervals than stipulated in the care plan. It was, however, the case that, contrary to Prison Service policy, there were occasions when Frances' SPAR booklet did not move with her when she attended appointments off the landing. This undermines the role of the booklet in ensuring effective communication between all of those involved in the care of a vulnerable prisoner.

## SECTION 9: KEY EVENTS BETWEEN 2 AND 14 APRIL 2011

Following the closure of Frances' fourth SPAR booklet on 1 April and the opening of her fifth on 15 April, she continued to attend Cognitive Behavioural Therapy (CBT) sessions and work in cottage industries on a card making project.

### Personal Journal

At around this time, Frances also began to write a journal which she titled *"Life as a Highbanker"*. In her journal, Frances described how it was for her when she was first committed to the prison and noted how she was "*stuck on the landing all day everyday,"* before getting a job in the gardens. She wrote *"The more time I spent on my own the worse the voices got and the worse the voices got the more I self harmed to stop them. I literally cut myself to ribbons or clawed myself to pieces."*

### Safer Custody Review

On 7 April, a Safer Custody case conference was held to discuss Frances, as a result of the referral made to the Safer Custody Team on 15 March. This was the first time she had been considered at a meeting of the Safer Custody Team. The role of the Safer Custody Team is the protection of vulnerable prisoners; the prevention of self-harm and suicide; and violence reduction. Referrals to Safer Custody can be made by any member of staff who is concerned about an inmate. As Frances' vulnerability was highlighted as soon as she was committed to prison, it might reasonably have been expected that staff would have considered referring her to the Safer Custody Team at that point, or when her first SPAR booklet was opened on 29 September 2010.

The case conference on 7 April heard input from staff on Frances' landing, a nurse officer who had had regular contact with her, a probation officer and the prison chaplaincy. The following very helpful action points were noted at the Safer Custody case conference:

- *"Request history update from Social Services.*
- *Invite social worker to the next meeting.*
- *Request progress report from CBT.*

- *To be seen by psychiatrist and wait feedback of same.*
- *To receive support through Opportunity Youth where her suitability for anger management through Probation is to be ascertained.*
- *Engagement in AD:EPT[19] to be deferred until feedback on CBT is received.*
- *Review in 2 weeks."*

No consideration was given to a review of self harm incidents or SPAR's to examine possible triggers, patterns or behaviours that might affect Frances' care plan. Factors that might have been relevant included Frances' feelings about being locked in her room and her sleep problems. It is also to note that, on occasions, staff recorded that Frances would tell them that she was fine when it subsequently became evident she was not.

**Psychiatric Assessment**

On 12 April 2011, Frances had her first psychiatric assessment since being committed to Hydebank Wood Prison on 22 September 2010. The reasons why it would appear that Frances was not assessed by a psychiatrist sooner were:

- Notwithstanding Frances' known history of self harm, suicide attempts and multiple admissions to Craigavon's Bluestone in-patient mental health unit, consideration was not given to the need for a referral to psychiatry by healthcare staff at the time of her committal or by a doctor who assessed her following her committal.

- A note on EMIS requesting a psychiatric assessment, made at Frances' first assessment by a mental health nurse on 8 November 2010, was not actioned.

- There was a lack of detailed understanding of Frances' medical history because her community GP/ hospital records were never requested.

The psychiatrist had asked Frances' mental health nurse to request her community psychiatric notes on 25 March, following Frances' urgent referral to her, but this was

[19] AD:EPT (Alcohol and Drugs: Empowering People through Therapy): a comprehensive substance misuse service, based in Hydebank Wood, that provides a multi component model of delivery.

never followed up. As a result, Frances' consent to the ordering of her notes was not obtained until the consultation on 12 April and the psychiatrist was unable to complete a full assessment of Frances. The psychiatrist recorded a summary of her consultation and noted that she would complete her assessment *"once I get her old notes. She remains on my list."* At interview, she said that it was "*extremely difficult*" not having the previous notes which would have given her "*the opportunity to see what antipsychotics* (medication) *she used before*." She said also that she did not know that Frances had been on Risperidone (antipsychotic medication) before coming into custody. As this had been clearly documented in Frances' prison healthcare notes, the clinical reviewer said that he found this "*surprising*."

The psychiatrist noted that Frances had been threatening self harm since coming to Hydebank Wood; that she said she planned to take her own life when she left prison and that she has been hearing voices since 2009. She noted also that Frances said she has been in Bluestone Mental Health Unit a number of times and had been diagnosed with Emotionally Unstable Personality Disorder.

The psychiatrist assessed Frances as "*calm but appeared guarded*" and "*feeling a bit anxious"*. She noted that Frances' sleep was poor and that she had said she was *"very low"* and had *"no motivation"*. She noted also that Frances reported hearing derogatory voices in her head telling her that she was *"worthless"* and *"no one would miss her"* and that she would lose custody of her children.

Commenting on the urgent psychiatric referral that was made on 25 March 2011, and why it then took a further three weeks for Frances to be seen, the psychiatrist said at interview that although the referral may be marked as *"urgent"* it is not always the case that the person needs to be urgently seen. She said that, because she has to prioritise her work between Maghaberry Prison and Hydebank Wood Women's Prison and Young Offenders Centre, she talks to the relevant mental health nurse following a referral to ascertain "*how urgently"* the assessment is needed.

The psychiatrist commented also that it was her understanding that individuals referred to psychiatry should be seen within nine weeks and those referred to mental health nurses should be seen within 13 weeks. The Hydebank Wood healthcare

manager said at interview that individuals referred to the mental health team are now seen within 21 days.

The clinical reviewer, Dr Fazel, commented that the timescales needed to be clarified and that nine to 13 weeks is too long to wait from referral to assessment.

Following Frances' referral on 25 March 2011, the psychiatrist also had a period of leave booked. At interview she said that *"if somebody is very floridly psychotic sometimes I can arrange to see the person on that day that I'm in there or in the next couple of days."* She said, however, that following her conversation with the mental health nurse on 25 March about Frances, she couldn't recall being presented with any information that made it necessary for her to be seen urgently. The psychiatrist said that if she had thought that Frances needed to be assessed earlier, she would have requested the Senior Consultant Psychiatrist in Maghaberry to have carried out the assessment in her absence.

In his clinical review report, Dr Fazel said that it was *"difficult to assess the quality"* of Frances' one psychiatric assessment but said that the psychiatrist *"covered important parts of her* [Frances'] *history and current mental state.* [The psychiatrist] *established that she planned to die from suicide after release from Hydebank Wood Prison, had received a diagnosis of Emotionally Unstable Personality Disorder, was suffering from internal voices, low mood, no motivation, poor sleep, and feelings of worthlessness and hopelessness.* (The psychiatrist) *decided on the basis of the interview to increase her Fluoxetine* (antidepressant) *medication and review her once her past psychiatric notes were received."*

**Telephone Calls**

Between 4 and 12 April 2011, Frances made four telephone calls to her husband, one on 4 April, two on 11 April and one on 12 April. During the calls, they discussed their relationship, their children and day to day matters. It is to note, however, that on 4 April, Frances told her husband that it had taken her six months of doing the *"wrong thing"* before she got any help in prison. Mr McKeown stated that he thought that she was getting help and Frances told him that she was getting help, but not the help that she needed. On 12 April, Frances told her husband that she had *"finally"* seen a

psychiatrist and that her antidepressant (Fluoxetine) medication had been increased and her Risperidone (antipsychotic medication) was to be further reviewed/changed.

**Continued Suicide Plan**

On 14 April, Frances met separately with a probation officer and Opportunity Youth. It is recorded that during both meetings, Frances made comments about her active suicide plan to kill herself once she was released from prison. It is also recorded that she said to her probation officer that she *"was biding her time until she gets an opportunity to do it right – she is content to wait until that opportunity presents itself."* It was noted that Frances did not present as being *"emotional or upset or even presenting as depressed more that she is content with the decision she has made and as such has some comfort from that."* It is also recorded that the probation officer spoke to the senior officer in Ash House and relayed the above information to him.

## SECTION 10: SPAR BOOKLET – 15 to 19 APRIL 2011

On 15 April, an officer who was concerned about Frances opened another SPAR booklet, her fifth since being committed to prison. The reason recorded for opening the SPAR was that *"Frances has been feeling very low for the past couple of days. I spent some considerable time talking with her this morning, during which she told me she didn't want to go on anymore and showed me a long letter she had written explaining her thoughts of suicide. She said she just pretended to be 'normal' and that voices in her head were there constantly telling her 'death was her way out'."*

It is recorded on the 'Immediate Keep Safe' action/care plan that Frances was to be moved to an observation cell and observed at intervals of no greater than 15 minutes. On this occasion, Frances did not object to being moved into the observation room.

During her SPAR assessment interview, it is recorded that Frances said *"she always has thoughts of killing herself but normally copes with these thoughts…not sure if she would be able to tell staff if she was going to harm herself."* There is no evidence that the feedback from the probation officer was considered as part of this assessment.

A further review took place on 16 April and it is recorded that Frances' situation had not changed. A record of the review notes that she was *"stressed out"* at being in the observation room *"but given her current feelings it would be prudent [for her] to remain"* there. It is also noted that Frances had fresh scratches on her arms, which she had done with her nails.

The following day, 17 April, a further SPAR review took place. A record of this meeting states that Frances no longer had thoughts of suicide and that she was confident she would speak to staff if her mood deteriorated. As a result it was agreed that she could return to her own room.

On 19 April, the SPAR booklet was closed. It is recorded that Frances was in *"good form"* and had no thoughts of self harm. On the same day, Frances attended a Cognitive Behavioral Therapy session where it was noted that *"Frances used humour throughout and couldn't be bothered when trying to demonstrate and talk about the*

*thinking model. Discussed 'road blocks' - more amenable thereafter…. Some understanding of 'just because I think I'm depressed doesn't actually mean that I am'."*

A review of the SPAR observation logs shows that staff interacted with Frances during the day, providing her with support and playing games of pool with her.

## SECTION 11: THE TWO WEEKS BEFORE FRANCES' DEATH

### 21 April 2011

On 21 April, Frances wrote in her personal journal *"Today has been one of my better days."* She wrote that she had attended a session with Opportunity Youth and that it was helping her with her confidence and ability to talk to people and *"express to them how I am really feeling."* Frances also wrote about having made *"good friends"* on Ash 4 and having *"good laughs"* with them. However she also wrote:

*"Even though I was on a good landing and had a good job I was still having a hard time with the voices in my head and my self harming. I had a hard time dealing with the voices I hear as I can't stop them. I am on medication but it doesn't help or stop anything. I had to battle to get to see a psychiatrist in here because the healthcare is so bad and there just isn't enough staff or doctors to cope with the number of inmates in the bank [Hydebank Wood Prison]. So getting to see a doctor is like finding a needle in a haystack. Even getting to see one of the mental health nurses in here is nearly impossible because there are only two of them….. So if you have any problems in here you are pretty much on your own or you rely on the other girls on the landing. They are great support for problems if you need someone to turn to. The best way to keep your problems at bay and pass your time in the bank is to keep busy and get off the landing as much as possible. That way you don't focus on your problems, but if you do, you always have a mate you can turn to for help."*

On 21 April, a Safer Custody Team case conference discussed Frances and considered the action points from the previous meeting on 7 April. A record of the meeting shows that Frances' social worker attended and provided information about her background and, in particular, her alleged childhood trauma, relationship difficulties and her diagnosis of Emotionally Unstable Personality Disorder. It was also noted at the conference that a SPAR booklet had recently been closed, though there is no reference to the reason as to why it was opened being discussed. Although not recorded as an action point on the case conference minutes, it was recorded in Frances' medical records by a nurse officer who attended the meeting that *"it was suggested that healthcare should take the lead in co-ordinating her care once assessed* [by the counselling/therapy providers such as AD:EPT, Cruse, NEXUS and CBT]*."*

**24 April 2011**

On 24 April, Frances wrote in her personal journal about how it was a quiet time in the prison because it was Easter and there were being a number of Bank Holidays. She noted that this meant that inmates were locked in their rooms for long periods because of there being limited staff on the landings. In relation to this she said:

*"I am a bad sleeper at the best of times so at night I lie in my cell and contemplate everything that has happened and everything that might happen in my life. It does bring me down but it is my pattern in life and I have become more accepting of it. I have a long term goal in life and it isn't to live. It is to die but it is not for a few years yet. It is something I have been contemplating and planning from I was 13 years old and now I know my plan of action down to the last detail. Life at present is in good form at the minute and I have very few problems or worries. The bank is sweet and calm at the minute. Being a Highbanker is hard because we torment ourselves and become our own worst nightmares while doing our time. Our minds are our most dangerous weapons so is time, too much time to think is a dangerous combination. Because I suffer from mental health my time for thinking is my biggest problem, when I have too much time to think on my hands that is when my mood lowers severely and I become suicidal. My thoughts make my mind snap and I just can't cope with it anymore so I self harm to try and stop it and block out the thinking and sometimes I even go far enough to plan a new way to end it all just to stop my pain from my thoughts. Once I lose the head and cut I end up on a SPAR and have to put up with being watched which makes my paranoia worse and the voices I hear go mad because of it and I stress out. It is the worst combination of emotions you could possibly imagine…..It is so uncontrollable and even to this day it scares me every time it happens and I have never been able to get control of it or used to it. The demons I suffer from I wouldn't wish on my worst enemy, it is a living nightmare. I do have good days, but they are few and far between, my life has been engulfed by turmoil and heartache. Since I have become a Highbanker I have had to face up to my problems a lot more since I can't use drink or drugs to block them out."*

**25 & 26 April 2011**

On 25 April, Frances wrote in her personal journal:

*"The healthcare in here is lethal, they are useless and don't care about the welfare of the inmates. They just do no more than they have to, to get through the day so we rely on ourselves to sort our own problems out.....Today is going to be a long boring day but there is no point complaining because nobody listens anyway. I don't think I'm going to bother eating today I have gone back into one of my funny moods again, which is the start of one of my bouts of depression. So my long cycle starts all over again. It is quite frustrating knowing I am going to suffer a bout of depression and suicidalness but I can't do anything to stop it. It is tiring...."*

On 26 April, Frances was visited by a nun who regularly visits the female inmates. Making a brief record of her contact with Frances, the nun noted that Frances was *"so so"* which, she said at interview, meant that she wasn't great.

Frances' personal journal for 26 April, only details that it was *"another long tedious day off"*, because of the Easter holiday and that they *"chilled out on the landing"* and that she was looking forward to returning to work the following day.

**27 to 30 April 2011**

Frances returned to work on 27 and 28 April and she also received cards and a gift from her mother and father for her 23rd birthday. Staff recorded that she was *"in good form."*

Frances also wrote to her mother and father and gave them visit numbers to see her.

On 29 April, there was a further Bank Holiday due to the Royal Wedding. Frances turned her attention to her personal journal again and wrote of *"long boring days"* because of not being at work and being locked on the landing.

**1 May 2011**

On 1 May, Frances wrote in her personal journal:

*"Sometimes it is hard but like today it was a relaxed day so it wasn't bad or too hard to cope with. Surprisingly I am having a relatively good run at the minute with my mental*

*health. The voices are good and keeping me company and I have no thoughts of wanting to self-harm at present so that is good."*

Writing about how her mental health affects her, Frances wrote, *"It starts with me starting to feel low and down, that is when the voices start to get derogatory and really nasty. They call me names and tell me to do things.....My mood continues to get lower and the voices get worse and that is when I start contemplating self-harm and suicide.....If the self harm doesn't take the pressure off my mood and the distress I'm in then I start contemplating how to go about killing myself.....My plan is not to die in a place like this but if things continue to get so bad for me, then I will end up topping myself in here.....There are people in here with real mental health problems like me, but there are those who just use it as an excuse to get attention. This means all the medical help and support we should be getting is going to time wasting.....So any time I need support I have to rely on myself to sort my own problems out. .....My mental health has been a constant battle for me my whole life from as far back as I can remember. It has always been an epic struggle and I have lost on so many occasions and probably will lose on so many more....As I was explaining before I have plans to die. They are complex plans with complex reasons behind them but I am intent and determined to carry them out....Even the voices in my head have agreed with my plan. It is just a matter of timing. It will all take place exactly two weeks after I am released from Hydebank."*

Frances went on to write about her *"two beautiful babies"* and how she thought that she would *"never be fit to look after them and that they will be better off without me and with people who can look after them and give them everything they need. I will always love my babies but I am just too sick to be able to look after them."*

Writing about the support she has received to deal with her mental health, Frances wrote, *"I have been dealing with the system for so long I can bluff my way through it with my eyes closed. The system and the doctors are no match for me because I can always tell them what they want to hear. If I told people how I truly felt then I would be locked up in a mental house for the rest of my days."*

**2 May 2011**

On 2 May, Frances wrote:

*"It is a relatively quiet day in the bank. I got up and got dressed and had a smoke and got my daily meds. I have also been put back on weekly issue, so I can't f***k that up again. I have to keep it sweet. There's no reason for me to take an overdose again so I should be okay…..The sun has been out all day so we went for a walk to do the rubbish and water the plants down in the gardens so it was good to get out for a bit, I also start Opportunity Youth OCN* (Open College Network) *(drug and alcohol) programme tomorrow so hopefully it will help me in my court cases. I'll do whatever it takes to prove to people that I can have my kids back again, because that is what I want more than anything in the world."*

**3 May 2011**

On 3 May, Frances started the Opportunity Youth OCN drug and alcohol program. A record of the session notes that Frances participated well in the group – listening, taking part and contributing. Following the session, Frances had a one to one session with the Opportunity Youth worker to discuss how she felt the session had gone. A record of this notes that Frances said that the OCN program *"went well"* and that *"she pushed herself to talk to someone she didn't like and this surprised her as she felt it was easier than she thought."*

During that day, Frances submitted a request for two small pouches of drum tobacco and cigarette papers from the tuck shop. She said that she was making the request as *"I have run out and none of the girls on the landing have any spare tobacco."* The request was refused the following day by a principal officer who said *"I am refusing this request as tomorrow is your tuck-shop day."*

During the last telephone call Frances made, which was to her husband on 3 May, they talked about their relationship and visiting numbers for the coming week, two of which she said she had sent to her parents and two she had kept for him. Frances also mentions that there was due to be a court hearing regarding custody of their children the next day.

In her personal journal, Frances noted *"Today has been a good day. I started OCN in exploring behaviours course and we looked at drugs and alcohol. I have to go again tomorrow and two days next week.....Then locked for the night and I wrote a letter to Brian and rang him as well. Was good to talk to him again. I do love and miss him."*

## SECTION 12: 4 MAY 2011, THE DAY FRANCES DIED

On 4 May, Frances had a further Opportunity Youth OCN programme session, which was again followed by a one to one session to ascertain how she felt it had gone. A record of this notes that *"Frances said she spoke in front of the group about herself and it went really well, she communicated to others regularly throughout the group and said she enjoyed taking part. Frances said she was feeling good and realised she deserves to get her kids back, have a job and is proud of herself for getting off drugs and alcohol. Meet tomorrow."*

At interview, an officer who was working on Frances' landing that day said that she was *"bubbly"*. He said that he had managed to get her a job painting the landing and rooms and that she was looking forward to starting it on Saturday 7 May.

Frances also attended the dentist on 4 May and placed a tuck shop order which would have been delivered to her within a few days.

### Code Blue

At 17.00 on 4 May, Frances' landing was unlocked to have tea. Within a few minutes an emergency alarm went off in Elm House[20] and a 'code blue[21]' was called over the prison tannoy system. Because of this, Frances and the other prisoners from her landing were locked up. At interview, a prisoner on the landing said that when Frances knew that they were going to be locked up early, she heard Frances say something like, *"that's another night I'm going to be locked up. I can't be f***king bothered to be locked up again."* Other inmates interviewed also recalled Frances saying something, at this time, which shocked them, but couldn't recall exactly what she said.

Another inmate said that the last thing Frances said to her on 4 May 2011 was *"I can't take any more of these lock-ups."*

[20] Elm House is one of the accommodation blocks for the male young offenders who share the same site as the Women's prison.
[21] Code blue means that there is a medical emergency to alert medical staff to the type of response required. There are a number of reasons why a code blue would be announced including when a casualty is unresponsive to voice or has a ligature.

The incident in Elm House related to a young man who had died by suicide[22].

CCTV shows that at 17.24 inmates left their rooms to collect their evening meal and fill their hot water flasks. At 18.05, CCTV shows that all inmates had returned to the landing and were locked in their rooms. From 18.54 two landing officers can be seen moving between the landing and kitchen, filling up inmates flasks again, taking out their dinner plates and taking cartons of milk and small boxes of cereal for those inmates who had requested them for their supper. At 19.25, the officers left the landing and the grill to the landing was closed over.

At interview, one of the officers said that when she asked Frances if she wanted any cereal or milk, she replied *"no."* The officer said that she remembered Frances was sitting writing at her desk at the time.

**Frances' Personal Journal Entry**

During the evening of 4 May, Frances wrote the following in her diary:

> ***'TIME TO DIE'***
> *"Today has been an ok week and day except this evening the voices are getting really bad. I can't put up with them much more. There was a code blue tonight on the wee lads house Elm. Code blue is when someone has hung themselves and died, so we are locked all night. If these voices keep up there will be another code blue tonight. I already have my noose made and ready but I can't do anything until the night staff do the alarms* [referring to the head count check which is routinely carried out at around 19.30]. *Then I have an hour….I've got it planned and tonight is the night."*

**Head Count Check**

CCTV shows that at 19.31, one of the two night custody officers on duty in Ash House went down the landing to carry out a head count check. At interview, he said that when he first looked into Frances' room he could not see her. He said that he called

[22] The circumstances surrounding the young man's inflicted death presents as a self inflicted death, however it should be noted that the Coroner's verdict is pending at the time of this report's publication.

her name to see if she was there and Frances, who he states was over to the left of her room as though she was kneeling down or sat on her chair, leant back and waved to acknowledge the check that the officer was carrying out. He said that she didn't speak to him but, *"I was just looking for a response and I got that so I moved on to the next inmate."*

CCTV at the end of Ash 4 landing shows that at 20.35, the second night custody officer on duty went down the landing to carry out a routine head count check. Two minutes later, CCTV shows that the officer walked off the landing to use the phone at the desk. At interview, the officer said that she was calling her colleague in the 'bubble'[23] to check whether Frances should be in her room. The officer and her colleague both said at interview that it was not uncommon for an inmate's card to be outside a room - indicating the room is occupied - only to find that the inmate is not in the room because, for example, they are on home leave or have been given bail. The identity card should, however, be removed if the room is not currently occupied.

Having phoned her colleague and been told that Frances was definitely in her room at the 19.30 check, the officer went back to the landing at 20.38 to check her room again. CCTV shows that, within 30 seconds, the officer returned to use the phone at the desk. The officer said that she called her colleague again and told him that she couldn't see Frances and wasn't getting a response. Both officers then agreed to carry out an emergency unlock.

**Emergency Unlock**

On entering Frances' room, the night custody officer saw Frances hanging by her dressing gown and cut the ligature. The night custody officer's colleague entered the room shortly afterwards and assisted with manoeuvring Frances onto the landing to check for vital signs and commence cardio pulmonary resuscitation (CPR).

Frances' husband asked why, as a vulnerable person, she was allowed to have a dressing gown cord in her room. It was the case that, as Frances was not on a SPAR at the time, she would have had all of her possessions in her room with her.

[23] The 'bubble' is in the control room for Ash House. It is in the centre of the house and is where CCTV can be monitored, keys and radios are stored and landing unlocks are managed. All landings in Ash House can be seen from the 'bubble'.

CCTV shows that, within two minutes of Frances being found, the senior officer, shortly followed by a nurse officer, attended the scene. Less than a minute after the nurse officer had arrived another night custody officer, who had responded to a radio communication of the emergency from Beech House attended the scene. No 'code blue' was used in this instance.

CPR continued and a heart start defibrillator was attached to Frances. Accounts from all in attendance confirm that, at no point, were there any signs of life.

At 20.56, CCTV shows paramedics attended the landing. Accounts from staff in attendance confirm that CPR continued but, again, there were no signs of life.

At 21.10, CCTV shows a doctor and cardiac team arriving on the landing. At 21.17, the doctor pronounced Frances *"life extinct"*.

**Suicide Letter**

In a separate letter, entitled *'My Suicide Note',* Frances apologised for what she had done and wrote of her children whom she said she loved *"with all my heart and soul and will always be with them"*.

Frances included in her note messages for her husband and parents and another inmate in Ash House whom she had become very close to.

In her final words Frances wrote, *"This is nobody's fault, it is my choice to die. People wouldn't listen to me when I told them how bad the voices I hear were and I just can't put up with it anymore. I'm so sorry. Goodbye. Frances."*

## SECTION 13: EVENTS FOLLOWING FRANCES' DEATH

### Death in Custody Contingency

In the event of an inmate dying, Hydebank Wood's Governor's Order 1-12 'Death of an Inmate' details the actions that are required by the communications room, duty governor, prison and healthcare staff.

The Prison Service policy documents, "Contingency Plans Forty Four and Forty Five – Death of a Prisoner" clearly detail the roles and responsibilities of all members of staff upon notification of possible death.

In line with the requirements of the contingency plans, the communications room, which controls and records all movements around the prison, immediately notified the appropriate personnel of the time and preliminary assessment of the cause of Frances' death. Those notified included the Police and the Prisoner Ombudsman.

### Family Notification of Frances' Death

One of the concerns raised by Frances' husband was that there was a two hour delay in notifying him of his wife's death. The investigation was also informed that Frances' parents found out about their daughter's death through the news coverage the following day.

Mr McKeown stated that when he attended the prison and asked about the delay in notifying him of Frances' death, he was told that attempts were made to contact him but that the prison could not get in touch with him. Mr McKeown stated that there was nothing wrong with the signal on his mobile telephone that night and there were no missed calls on his phone, except for one around 22.45 from a private number, which turned out to be the prison. Mr McKeown stated that there may be many people who, for whatever reason, will not answer a call from a private or withheld number and that this should be looked into.

The log of action carried out, completed by the communication room does not record when Mr McKeown was contacted.

As part of the committal process, inmates are requested to provide next of kin details in the event of an emergency. Inmates are only asked to provide the details of one person and Frances provided Mr McKeown's details. It was, therefore, the case that staff believed that Mr McKeown was the only person that they should contact following Frances' death.

Not withstanding this, the investigation found that a prison psychologist made strenuous efforts to make contact with Frances' parents. Although this was policy compliant, it was deeply regrettable that Frances' parents learned of her death through media coverage.

A staff de-brief meeting which took place on 17 May, noted the following in respect of family liaison following a death in custody:

> *"Governors must have in place a local protocol explaining what support will be offered to a family bereaved by a death in custody. Informing relatives must be handled with sensitivity and sympathy, and using the telephone to deliver news of a death should only be used as a last resort. Contact with relatives should be made directly by chaplains or by responsible individuals within the community, including Police, Parish Priests or Ministers who may be accompanied by a representative from the establishment. Best practice elsewhere suggests that it may be appropriate for the Governor to appoint a senior member of staff or a dedicated Family Liaison Officer (and a deputy to cover absences) as a named point of contact for the family, to manage the day-to-day partnership between the prison and the family following a death in custody and to provide information and practical support. A Family Liaison Officer should also accompany the Chaplain to the first meeting with the family. If the family does not want contact with the prison, their wishes should be respected and they should be given written information about how to make contact later should they change their minds."*

## SECTION 14: STAFF SUPPORT AND DE-BRIEF MEETINGS

### Hot De-Brief

The Prison Service's Self Harm and Suicide Prevention policy, issued February 2011 states:

*"In all cases involving a serious incident of self harm or death in custody, hot de-briefing will take place and will involve all of the staff (where possible) who were closely involved with the incident.*

*The hot de-brief will be held by the Duty Governor or the most senior manager at the time (depending on the circumstances of the case) and will take place as soon after the incident has been brought under control as possible. During the hot de-brief staff should have the opportunity to express their views in relation to how the situation was discovered, managed and any additional support or learning that could have assisted. In addition, the hot de-brief is an opportunity to identify if staff themselves require specific support."*

The policy also requires that a record of the hot de-brief will be completed and a copy made available to the Head of Custody Branch and to the Prisoner Ombudsman.

Following the removal of Frances' body from the prison, a hot de-brief took place in the recreation room of Ash 4, with a number of staff involved in the incident and those who assisted in managing the scene afterwards present. The members of staff who carried out the emergency unlock, along with the nurse officer who attended the scene had located themselves in the healthcare centre and as such the Governing Governor spoke to them separately. It is noted in the record of the hot de-brief that all staff were informed of the support services available.

### Cold De-Brief

The Self Harm and Suicide Prevention policy also states that, *"a cold de-brief will take place within 14 days of the incident to provide opportunities for staff to further reflect on the events surrounding the death in custody and to, perhaps, identify any additional*

*learning from the events. The cold de-brief* ***is not*** *intended to be a comprehensive investigation into the circumstances. Rather, it is an opportunity for staff to express their views and share their thoughts about the incident and their role and involvement in it. A member from PSHQ (Prison Service Headquarters) Custody Branch will attend the cold de-brief to support the Governor conducting it."* It is also a requirement of the policy that a record of the cold de-brief is made.

It is recorded that a cold de-brief, *"touching on"* the deaths of Frances and the young man who both died on 4 May, took place on 17 May 2011. The meeting was chaired by the Head of Safer Custody who was supported by two of his colleagues from Prison Service Headquarters. It is recorded that *"the objective of the meeting was to give the staff involved in both incidents an opportunity to air their views and concerns around the reaction of colleagues and other relevant agencies to these events."* The record of the meeting does not note who attended.

It is recorded that issues of concern arising from the events of 4 May were raised by staff involved in each of the deaths. These included:

- *"the lack of support services available to staff following a critical incident"*
- *"support services not being readily available for night guard staff"*
- *"lack of immediate support from healthcare managers and the Trust"*
- *"information available at the time regarding support services was scant"*
- *"concern that the regular staff in Ash 4 had not been called into the centre to lend support to the other female prisoners who were very upset by this tragedy"*
- *"contact numbers for staff were out of date…..and some staff listed had retired"*
- *"medical response bags contain too much equipment, some of which is not necessary"*
- *"defibrillators being more readily available throughout the prison…and sited in more accessible places"*

At interview, staff also raised the following concerns:

- That the cold de-brief was scheduled to take place at 07.30 following a 12 hour night shift, and did not start on time. Staff stated that they would have

attended on a rest day or that the meeting should have been convened at the beginning of their shift.

- The cold de-brief covered the events of both deaths that occurred on 4 May and that staff who dealt with Frances' death felt that it was unhelpful for them to have to sit through the events of the young man's death also. As a result the two officers who carried out the emergency unlock for Frances, left the meeting at around 08.10, whilst they were still discussing the young man's death and were not present when Frances' death was discussed. It is to note that this was not documented on the minutes of the cold de-brief.

## SECTION 15: ALLEGATION THAT FRANCES WAS BULLIED

### Background

Early in the investigation into Frances' death, the Prisoner Ombudsman became aware that, on the 17 January 2011, a member of her family had written to Hydebank Wood Prison outlining concerns that Frances had said that she had witnessed inappropriate behaviour involving a prison officer and an inmate and that she was going to "*get beaten by the lady in question.*"

The Prisoner Ombudsman also received an anonymous letter from a "*concerned staff member*" at Hydebank Wood who alleged, that Frances McKeown had been bullied and threatened by other prisoners.

During the course of staff and prisoner interviews, it became evident that others believed that some inmates had treated Frances in a way that could be described as bullying. This was said to be as a result of inmates believing that Frances had told the security department at Hydebank Wood that she had seen a male prison officer kissing a female inmate (Inmate A). Concerns were raised that Frances' treatment by some prisoners might have contributed to her death.

The Prisoner Ombudsman determined that all of these matters and concerns should be investigated.

The investigation established that it was the case that Frances had told other inmates, in December 2010, that she had seen a prison officer kiss Inmate A. The investigation found that Frances did not, however, approach prison security staff with this information, but that the security department became aware of the allegation made by Frances, by other means. It was the case that Frances was subsequently spoken to by security staff and Frances did confirm what she had said. Frances told other inmates that security staff had spoken to her but said that she had "*told them nothing.*"

During the course of the investigation the Prisoner Ombudsman became concerned that the allegation made by Frances had not been adequately investigated and she

informed Prison Service Headquarters of this on 5 April 2012. The Prisoner Ombudsman was subsequently informed that the Governing Governor at Hydebank Wood had given an assurance that the allegation had been investigated and that there was an investigation file.

In light of this, the Ombudsman said that she would continue with her investigation and report her findings in connection with this matter in due course.

**Prison Service Investigation into the Allegation made by Frances**

The Prisoner Ombudsman has a duty to bring to the attention of the Prison Service and/or the South Eastern Health and Social Care Trust any matter which comes to light during the course of an investigation that she believes merits immediate attention.

In light of her early findings in connection with the Prison Service response to the allegation by Frances McKeown that she had seen a prison officer kissing an inmate, the Prisoner Ombudsman produced a report, specific to this issue, to the Prison Service. In this report, the Prisoner Ombudsman made it clear that she believed that further investigation of the adequacy of the investigation into the allegation made by Frances and the action subsequently taken, was required. The Prisoner Ombudsman also, however, stated that this further work fell outside of the scope of her investigation into the death of Frances.

The conclusions section of the report *"Investigation of a Matter in Connection with the DIC of Frances McKeown*" stated the following:

1. *"The Governor at Hydebank Wood Prison has a duty of care to female inmates.*

2. *The Governor made it absolutely clear that if the allegation made by Frances McKeown, that Officer C kissed Inmate A, was found to be true he would regard this as a serious disciplinary matter.*

3. *The investigation that was carried out into Frances McKeown's allegation by the Security Department and the Ash House Governor was wholly inadequate. The*

*attitude and approach to the investigation was not appropriate to the duty of care owed to female inmates and this duty was, therefore, breached.*

4. *The Governor did not take any steps to ensure that the findings reported to him were reasonable and appropriate in light of an allegation that he said that he viewed as very serious, if substantiated.*

5. *The arrangements for carrying out internal investigations at Hydebank Wood Prison are not appropriate.*

6. *Protocols, recording mechanisms, supervision arrangements, quality assurance arrangements and staff training in the security department at Hydebank Wood Prison are not appropriate."*

**Prison Service Response to the Prisoner Ombudsman's Early Report**

As a result of the Prisoner Ombudsman's report, the Governing Governor of Hydebank Wood was suspended in May 2012 and an external independent investigation commissioned. Following the external investigation, the Governing Governor was charged with misconduct in August 2012.

**Allegation that Frances was Bullied**

At interview, the governor of Ash House at the time of Frances' death was asked if she had any knowledge of Frances being treated badly by other inmates after she alleged that she had seen an officer kissing an inmate.

The governor said *"some of the girls had said that they weren't speaking to her (Frances) because of the allegations.*"

Asked if she had been told this by the inmates concerned, the governor said "*no, I think it was anecdotal evidence that some of the staff were saying that there was a bit of tension... well not tension, tension is the wrong word, but there was a bit of quietness on the landing. And as far as I remember, I went back and asked Frances did she want to move off the landing and I think... this is only I think... there was... we had some very*

*difficult prisoners on A3 at the time and on A2 and it was our opinion and Frances's opinion that she was best off on the 4s."*

Asked what staff had told her, the governor said *"Staff were just saying that there was a bit of quietness and it was very hard to get to... you know, females in Ash House it was happening all the time that there was some difficulties, quietness, some... because what I was trying to get to was their sides on this you know? Was there anybody on Frances's side or was there two sides?"*

The governor said she could not recall anyone actually telling her that inmates were being unkind to Frances or that she was not taking her meals or leaving her room.

Asked if she would have expected to have been told this if it was happening, the governor said *"I would, I think I would have because there was... I mean, I would have because there was a few vocal prisoners that I would have had close contact with and I think if staff... because they would sometimes come to me and say, "Do you realise that x, y and z is happening?" And I would expect but there would be no guarantee that they would have come to me or I may not have been about."*

The governor was unable to recall which members of staff she spoke with but said that it would have been staff on Ash 4 where Frances was located.

**Staff Evidence in Respect of the Bullying Allegation**

The investigation interviewed several prison officers and senior officers who had responsibility for Frances during the period when it has been alleged that she was being bullied by other inmates. Only one of the staff interviewed had any knowledge about the allegation made by Frances, that she had seen a prisoner officer kissing an inmate, at the time that it was said to have occurred in December 2010.

All prison staff who were interviewed said that it was well after the death of Frances in May 2011 that they became aware of this matter. They said also that Ash 4 was generally considered to be a settled, *"quiet, more mature"* landing.

Whilst the governor had said that *"Staff were just saying that there was a bit of quietness"* only one of the prison officers interviewed could recall this. The officer said that other inmates believed that Frances had been *"telling lies"* and there was *"a bit of tension."* He said that *"before they might have sat down and had a wee chat in each other's cells or in the association room, they didn't seem to do that with her, except (Inmate name redacted – Frances' friend)."* The officer said that he couldn't remember Frances *"getting a hard time because I think Frances was, would have been the type who could look after herself, to be honest with you,"* but the *"atmosphere wasn't brilliant."* The officer said that when Frances returned to Ash 4 in the weeks before her death the same inmates were there, but *"she got on alright with them."*

None of the other staff interviewed recalled Frances being badly treated by other inmates but all accepted that it could be possible for there to be some ill-feeling between inmates without them being aware of this, though some said that they would be surprised if this was the case.

The three senior officers responsible for Ash House at the time all said that their main contacts with Frances were in connection with the implementation and review of SPARs when Frances was considered to be at risk of self harm. The senior officers said that Frances would talk with them about her children; her relationship with her parents and her husband. They said that these were the matters that she was most concerned about.

One senior officer, who said that Frances shared very personal information with her over a number of discussions, described Frances as a *"very, very, very sad, sad lonely girl"* who would have an *"awful emptiness about her."* The senior officer said that it was more difficult to notice a change in Frances than *"if you have somebody very gregarious who suddenly goes quiet."* She said that, in the case of Frances, she was *"way down there to begin with so you're always aware of Frances. So seeing a change... she was always quiet, down, reserved, sad, lonely you know?"*

The senior officer and other staff said that Frances went through phases where she *"didn't socialise much."* One officer described Frances as *"not a very sociable person"* and *"hard to get to know."* She said that when Frances was feeling very low, this would affect her behaviour and described an occasion where she opened a SPAR for

Frances because of this. Another officer said that she could *"never tell what Frances was thinking"* and that Frances *"sort of held herself back, you know, kept herself really private."* A different officer said that *"Frances wouldn't have been one for chatting, (she) kept herself to herself."*

**Inmate Evidence in Respect of the Bullying Allegation**

It is to note that one inmate interviewed in prison and one interviewed outside of prison alleged that the officer, about whom Frances made the allegation, encouraged the inmate he was alleged to have kissed (Inmate A) to treat Frances badly. These allegations have been brought to the attention of the Prison Service.

A number of inmates and ex-inmates spoke with the investigation about their experience of Frances and a number of them said that Frances had been treated *"meanly"* by other inmates after she made her allegation. Some of the inmates also said that they were worried that they might be bullied themselves by other inmates for providing the information to the Prisoner Ombudsman.

As previously detailed, on the 17 January 2011, a member of her family wrote to Hydebank Wood Prison outlining concerns that Frances had said that she had witnessed inappropriate behaviour involving a prison officer and an inmate and that she was going to *"get beaten by the lady in question."*

A number of inmates confirmed to the investigation that, because it was believed that Frances had told security staff that she had seen a prison officer kissing an inmate, this had lead to an argument between Frances and the inmate concerned and, at one time, the two had to be separated by staff because they were going to fight.

Inmate B said that, because inmates believed that Frances had told security staff that she had seen a prison officer kiss an inmate, "*some of the girls on landing 4* (inmate names given but redacted) *would say "you can't tell her nothing, don't say nothing in front of her."* Inmate B said that Frances "*was isolated when they were in and out of each others cells. Before that she was so good hearted and trying to be accepted, so they would be in and out of her cell... They weren't nice to her in the gardens... She left the gardens, because of this I think."*

At interview, Inmate C said that it had been suggested by other inmates that Frances had been bullied by a particular inmate. Inmate C said that she did not see this and did not think it likely.

Inmate D said *"I was on the way back to Ash House from visits, I don't know when. It was apparently a day or two after an allegation was made against (Inmate A) by Frances McKeown. This related to Frances claiming that she had witnessed (Inmate A) and a male member of staff kissing … An inmate was walking with me and shouted down to someone in the gardens and made a reference to watch themselves with the liar standing beside them (Frances)."*

Inmate E said that *"some of the girls would have been annoyed for (the officer concerned)."* She said that *"there was a tense atmosphere, that these girls ignored Frances and maybe gave her dirty looks but that this was the height of it. These girls were all talk, they wouldn't have actually done anything but they probably tried to exclude Frances. This continued for about two months."*

Inmate E also said that Frances stopped working in the gardens which she said she thought was strange because "*Frances liked the gardens*." She said that she didn't see Frances around as much at this time but did recall seeing her on her own. Inmate E said that she thinks that Frances may have been trying to avoid these girls and that the only place she could do this would have been in her room. She said also that "*there were a lot of lock-ups around this time*". She said that she and other girls *"did not want to get involved and said nothing to Frances about the situation"*. She said also that Frances asked to move from Ash 4 (on 15 January 2011) because of the way the girls were treating her. She later asked for a move back to Ash 4 (on 14 March 2011).

Inmate F said that, after Frances returned to Ash 4 she became good friends with another inmate and that other inmates would ignore the two of them. She said that *"Frances wouldn't let anyone give her a hard time physically but this was different, this was more like mental bullying."*

**Related Findings**

It is to note that, during the period that it was alleged that Frances was being bullied by other inmates, she was reported to be self harming less and was not on an open SPAR. It is also the case that, whilst there are many references to the matters troubling Frances in prison records, there are no references to her being troubled by her treatment by other inmates.

The investigation did, however, find that Frances did stop working in the gardens on 23 February 2011 and went to work instead in Cottage Industries. She subsequently asked to return to the gardens on 20 April 2011.

Frances was moved from Ash 4 landing on 26 January 2011 whilst it is recorded in prison notes that the move was for *"operational reasons"* and the governor said that this was her understanding, it was in fact the case that Frances requested the move on 15 January 2011 stating *"I would like to request permission to move landings off Ash 4 as I have too much trouble with another inmate and it is starting to affect my mental health. I feel it would be better for both parties for us to be separated as we can't work our differences out."* Frances was moved to Ash 3 on 26 January 2011. On 10 February 2011, Frances was further moved to Ash 1 landing following an accusation that she was one of a number of inmates accused of bullying another inmate. Frances admitted putting a notice on the inmate's door calling her *"a tout."*

Frances returned to Ash 4 on 14 March 2011 and she recorded in her diary on 21 April 2011 that she was on "*a good landing*" that Ash 4 was "*the landing to be on*" and that it was *"the most settled landing in the house".* From 14 March to Frances's death on 4 May she was good friends with another inmate on Ash 4. On 3 April, however, Frances did raise a complaint about a particular inmate on her landing whom she wrote was *"intimidating and bullying towards inmates on the landing."* A number of the other inmates interviewed mentioned also this inmate's attitude towards Frances. Frances asked for her complaint to be investigated but was told by a senior officer that Frances needed to complete a Challenging Anti-Social Behaviour form. In the event, there is no evidence that Frances completed the further form.

On 21 April 2011 Frances wrote in her journal:

*"As I was saying before we look out for one another but because we are confined to a small space we do sometimes loose the head with each other and fight, these are just part of the down times we have, when we fight it is just normally shouting and screaming not punching or kicking or anything serious. Instead of letting us sort things out between ourselves the screws hit the panic buttons and the whole complex gets locked down until it is sorted out. But when it is over it is over everyone gets back on with their lives and their routine. Even I have had my runs ins with other girls in the house, but like I said when its over its over and everyone knows where they stand."*

In the days before her death, Frances can be seen on CCTV sitting and talking with other inmates on the landing and at cottage industries.

The evidence available appears to suggest that, whilst Frances was not physically abused, she was ignored and spoken to in a way that could be described as bullying. In the case of some inmates, this appears to have continued for an extended period, though it is not possible to say, with any certainty, for how long. Whilst it is not possible to say what impact this had on Frances' already fragile mental health, an examination of all the related evidence suggests that it is unlikely that bullying by other inmates was a direct cause of Frances' death at the time when it occurred.

As stated, for the seven and half weeks before her death Frances had become very good friends with an inmate that she did not previously get along with. She said in her journal that the two had become *"best mates"* and spoke at length of the time that they spent together smoking, chatting, playing music and washing their clothes. She said they *"chilled out and had a laugh with each other."*

Frances' friend said that *"the week before she died we were playing football up in the fields and we had a great laugh. She was in good form. The night before she died, she was singing and dancing in my cell. I don't know whether it was a cry for help, I'll never know now. I think there were far too many lock ups. I don't understand why we were being locked just because the boys* (in the Young Offenders Centre) *were being locked."*

## SECTION 16: AUTOPSY REPORT & FRANCES'S ROOM SEARCH

An autopsy examination was carried out on 5 May 2011 and gave the cause of Frances' death as:

I (a) Hanging.

The report states:

*"There was no evidence of pre-existing significant natural disease and nothing to suggest that the deceased had been the victim of an assault.*

*There were a large number of scars on both forearms consistent with self-infliction and indicative of low self-esteem."*

Toxicological analysis of a sample of blood taken at autopsy revealed the presence of antidepressant drugs Fluoxetine and Trazodone and the antipsychotic Risperidone at concentrations that lay within their respective therapeutic ranges. Further analysis of the blood sample was negative for alcohol and other common drugs. The report states that, *"There was nothing at autopsy to suggest that this was anything other than an act of wilful self-harm."*

It is to note that Trazodone was not prescribed to Frances whilst in prison. It is not known from whom Frances obtained Trazodone but the investigation established that a number of other prisoners on Frances' landing were being prescribed this whilst she was located there.

Commenting on the drug Trazodone, Dr Malcolm VandenBurg said that *"Patients with a history of suicide-related events, or those exhibiting a significant degree of suicidal ideation prior to commencement of treatment with Trazodone are known to be at greater risk of suicidal thoughts or suicide attempts, and should receive careful monitoring during treatment,"* particularly in the early stages of its use. As previously stated, Frances was not prescribed Trazodone and it is not, therefore, known for how long she had been abusing it.

Dr VandenBurg also pointed out that Fluoxetine is subject to similar warnings. He said, therefore, that in relation to Frances, particularly as she was under the age of 25, *"there would have been a summation of effects, if not true enhancement."* Dr VandenBurg said that there are reported cases of suicidal ideation and behaviours when Fluoxetine and Trazodone are combined.

Noting that Frances was prescribed the antipsychotic medication Risperidone, Dr VandenBurg said also that *"the manufacturers warn in generality that the sedative effects of the antipsychotic and Trazodone may be intensified when prescribed together and that is why Frances may have been using Trazodone for the sedation of it alone and the sedation in combination with the Risperidone."* As stated previously, it was the case that Frances had difficulty sleeping at night.

Dr VandenBurg further said that administration of antidepressants in patients with psychotic disorders may result in a possible worsening of psychotic symptoms and paranoid thoughts.

Dr VandenBurg said *"In summary it may be highly significant that Frances McKeown was abusing Trazodone because of its own effects on suicidality and its own adverse experiences, all of which could have been increased by the prescription of Fluoxetine and Risperidone....In the unmonitored environment with potentially varying doses of all drugs, the combination could have been disastrous."*

A full summary of Dr VandenBurg's report is in Section 17.

## SECTION 17: FINDINGS OF THE EXPERT CLINICAL REVIEWERS

### Review by Dr Seena Fazel- Consultant Forensic Psychiatrist

Some of the findings of Dr Fazel's clinical review have been included at appropriate places throughout this report. Below is a summary of key findings.

#### Prescribed Medication

Dr Fazel noted that on committal, Frances' GP was phoned and the correct dose of her Risperidone was issued. He said that this was good practice. He pointed out, however, that after a few weeks in custody, during which she reported low mood and suicidiality, Frances explained that she had felt better previously on a combination of Quetiapine (125mg) and Fluoxetine (40mg).

Dr Fazel said that "*She was prescribed Fluoxetine at 20mg, an appropriate starting dose, but it was only increased in April 2011 to 40mg. It may have been beneficial to her to have the dose increased earlier, and I note that [a nurse officer] recommended this on 27/11/10 but this does not appear to have been followed through. In addition, an increase in her Risperidone dose or replacing it with quetiapine may have been helpful as she reports on a number of occasions to staff that the internal voices were problematic to her. These medications are antipsychotics and likely to dampen down such internal voices, although their use has to be closely monitored for side-effects. Current recommendations, such as those by NICE[24], do not recommend their medium or long term use in individuals with personality disorder due to their side effect profile.*"

Dr Fazel pointed out that Frances had been diagnosed with Emotionally Unstable Personality Disorder and said that *"there is no standard medication regime in order to treat this disorder, and there is more evidence that psychological treatments will address underlying problems associated with this disorder. However, it is not uncommon to treat symptoms of this personality disorder…[with] medication….as part of the treatment of comorbid conditions such as depression, anxiety or psychosis."*

[24] NICE (National Institution for Health and Clinical Excellence): Develop evidence based guidelines on the most effective ways to diagnose, treat and prevent disease and ill health. It was set up to reduce variation in the availability and quality of NHS treatment and care.

Dr Fazel said that it is possible that Frances' did have a *"comorbid depression"* and that this would explain why she was using Fluoxetine. He noted that *"her GP records refer to a diagnosis of depression in 11/2009 and 8/2010 (although it is not clear whether this diagnosis was made after psychiatry) and her parents describe a post natal depression."*

Dr Fazel also said that there is no suggestion from Frances' records that she had a primary diagnosis of a psychotic illness such as schizophrenia, although *"individuals with emotionally unstable personality disorder often experience psychotic like symptoms (such as internal voices), particularly at times of stress."* Dr Fazel said *"it is these symptoms that could benefit from the short-term use of antipsychotic medication, and it appears from her self report that she did experience benefits from these medications in the past for her internal voices."*

**Psychological Support**

Frances attended Cognitive Behavioural Therapy and some group psychological work (through Opportunity Youth). Dr Fazel said *"This is good practice as individuals who are on the more severe end of the spectrum of personality disorder (as I think Ms McKeown was) are unlikely to benefit from medication solely, and psychological treatments are recommended by NICE and other expert opinion. However, for some individuals with such disorders, specialist advice from a local forensic psychiatric service is appropriate, particularly if there is an escalation in self-harm or violence and there is some evidence that psychological therapies may benefit the individual."*

**Mental Health Assessments**

Frances was first reviewed by a mental health nurse on 8 November 2010 (around six weeks after committal) and first assessed by a psychiatrist on 12 April 2011 (over six months after committal). The EMIS records made mention of a referral to a psychiatrist on 8 November 2011 but this referral was not actioned. An 'urgent' psychiatric referral was made on 21 March 2011. There was a further three week delay before Frances was seen.

Dr Fazel said that, in his opinion, *"these delays in assessment are not appropriate. For someone with a history of 11 inpatient episodes, who enters prison on a major tranquiliser and suicidal with significant psychosocial problems, I would have thought that Ms McKeown should have been seen urgently by a mental health nurse within a week of committal, and within two weeks of a referral from a mental health nurse by a psychiatrist.*

*The other related concern is why a psychiatric assessment was not requested at an earlier stage. On 1/10/10, the prison doctor reviewed Ms McKeown, whilst she was on a SPAR, and was told by her that she had been a psychiatric inpatient on 11 previous occasions. This could have led to a referral for an assessment by a psychiatrist…… In relation to the quality of the assessments themselves, once they were undertaken, I believe overall that the nursing assessments appear to have been done appropriately."*

Dr Fazel further said *"It is my view that timescales need to be clarified to all the healthcare staff that nine and 13 weeks are too long to wait from referral to assessment, and I would recommend that the same standards applied in the community are considered as targets in prison healthcare."*

**Absence of Community Psychiatric Records**

At no time were Frances' community medical requested by prison healthcare staff. Frances' healthcare notes were requested on 25 March 2011, but this was not followed up. Dr Fazel said that, in his view, these previous medical records would have assisted medical staff in their assessment of Frances, particularly if her mental state deteriorated or there was an escalation in the frequency or severity of her self-harm. He said, *"this is partly because previous hospitalisations were likely to have been associated with worsening in her mental state or suicidality, and therefore medication and other strategies will have been clearly documented and what effect they had. In particular, if it was in fact the case that Quetiapine treated her increasing internal voices more effectively than other major tranquilisers, this information may have been important. I note that in her personal diary on the day of her suicide, she states that the voices in her head 'were getting really bad'."*

**Other Observations**

Dr Fazel also made the following observations.

1. *Ms McKeown's police custody records are not recorded by prison healthcare to have been received on committal. Her custody records would have been helpful to highlight her suicide risk, and consideration to locate them could have been considered.*

2. *I note that a referrals book is used to document referrals made to psychiatry by the mental health nurses. A more transparent system with automatic reminders if referrals have missed deadlines could be considered.*

3. *In individuals who enter prison with a history of psychiatric hospitalisation and who continue to be on psychotropic medication, consideration should be given for requests for both GP and hospital medical notes to be made part of the standard assessment process on committal to prison.*

**South Eastern Health and Social Care Trust's Response to Dr Fazel's Clinical Review**

Having reviewed Dr Fazel's clinical review report, the South Eastern Health and Social Care Trust confirmed that they had no comments to be considered in relation to the factual accuracy of his report.

**Addendum to Dr Fazel's Report**

Following receipt of Frances's community medical records, access to which was delayed for legal reasons, Dr Fazel wrote the following addendum to his report:

*"I reviewed two files of community medical notes that provide detailed inpatient and outpatient records from 2009 onwards. In summary, a review of these notes does not materially change any of my conclusions in my clinical review Report. The notes outline clearly a diagnosis of Emotionally Unstable Personality Disorder – borderline type (also known as borderline personality disorder), document a history of serious self-harm*

*including an overdose of between 80-96 Paracetamol tablets in December 2009, recent inpatient admissions to psychiatric hospital, and periods on medication and periods without any medication. They also confirm that she had been prescribed Fluoxetine* (an oral antidepressant), *Risperidone and Quetiapine* (both oral antipsychotics) *previously. I note that her medical records state there was no evidence of 'pervasive depression' or psychosis (see, e.g., Discharge summary dated 4/2/10).*

*However, these medical notes underscore two previous comments in my previous report. The information on the previous use of Quetiapine would have potentially assisted the prison doctor in re-starting this medication. There is not evidence, though, that Quetiapine was more effective than other medications in treating her symptoms.*

*In addition, a mental health assessment dated 5/12/09 in relation to Ms McKeown's large overdose of 80 -96 Paracetamol tablets state that she had been hearing 'voices 3-4 days', which highlights that one of Ms McKeown's triggers for serious self-harm included an increase in these voices. This may have informed decisions such as that taken by the prison doctor to stop her medication. Her previous medical notes do not suggest that antipsychotics were previously used by Ms McKeown as a drug of abuse as perhaps implied by the prison doctor.*

*I have no other comments to make in relation to Ms McKeown's community medical records."*

**Review by Dr Malcolm VandenBurg – Specialist in General Medicine and Consultant Pharmaceutical Physician**

Dr VandenBurg commented on the significance of Frances taking the non-prescribed antidepressant Trazodone with her prescribed medication Fluoxetine (an antidepressant) and Risperidone (an antipsychotic).

Dr VandenBurg made the following points:

- "Frances' previous self-harm and her age, were risk factors for both Trazodone and Fluoxetine to increased suicidality.

Additional risk factors for this would be varying doses of them, which is quite likely to happen within the prison context.

- Frances was probably using Trazodone as it is more sedative than her other two medications, although not as sedative as some other antidepressants. Trazodone is an antidepressant tablet from the class known as triazolopyridines. It is unrelated to the SSRIs (selective serotonin re-uptake inhibitors) like Fluoxetine. Its mode of action is not precisely known, but it is likely to have some effect potentiating central neuro transmitters such as noradrenaline and may have an anti serotonergic effect on the brain.

- It is not known which dose Frances was taking, but it would seem to be "*a normal therapeutic level*". It is not known whether she varied the dose or if it was a consistent dose.

- Trazodone is indicated for anxiety, depression and mixed anxiety and depression. There is no contra indication to its use in a 23 year old lady. The dose needs altering in hepatic impairment[25] and also has to be used with caution in those in severe renal failure. In the case of Frances, the renal failure is unlikely to be of significance, however, the hepatic metabolism[26] may be because of Frances' alcohol usage. It is to be hoped that while in prison Frances was not able to use alcohol, although this can never be guaranteed and there may be long term liver damage consequent on alcohol use and other matters.

- The manufacturers note that Trazodone use may be associated with suicide/suicidal thoughts or clinical worsening. Their Summary of Product Characteristics (SPC), in Section 4.4 entitled "*Special warnings and precautions for use*" states:

  *"Depression is associated with an increased risk of suicidal thoughts, self harm and suicide (suicide-related events). This risk persists until significant remission occurs. As improvement may not occur during the first few weeks or more of*

[25] Hepatic Impairment: Impaired liver function.
[26] Hepatic Metabolism: Constellation of chemical alterations to drugs in the liver.

*treatment, patients should be closely monitored until such improvement occurs. It is general clinical experience that the risk of suicide may increase in the early stages of recovery… Patients with a history of suicide-related events, or those exhibiting a significant degree of suicidal ideation prior to commencement of treatment are known to be at greater risk of suicidal thoughts or suicide attempts, and should receive careful monitoring during treatment.*

- The SPC also states that: *"Close supervision of patients and in particular those at high risk should accompany drug therapy especially in early treatment and following dose changes. Patients (and caregivers of patients) should be alerted about the need to monitor for any clinical worsening, suicidal behaviour or thoughts and unusual changes in behaviour and to seek medical advice immediately if these symptoms present".*

- Similar risks are noted in the SPC for Fluoxetine, so Frances would have been subjected to the effects of both, as she was under the age of 25. There would have been summation of effects, if not true enhancement.

- There are a number of other special warnings, particularly that administration of antidepressants in patients with psychotic disorders may result in a possible worsening of psychotic symptoms and paranoid thoughts. There may have been an interaction with Fluoxetine, and Risperidone, in many ways. Not only may side effects be worse, but there may be an interaction to produce a serotonin syndrome[27] or a neuroleptic syndrome[28] when these substances are used together. Particularly akathesis[29] may occur and this may be so disturbing as to induce suicidal ideation and action.

- When Trazodone is stopped, there should be a gradual dosage reduction to minimise the physical and psychological effects of the withdrawal syndrome, which again can increase the suicidal ideation and if Frances was using it

[27] Serotonin syndrome: Potentially life threatening drug reaction.
[28] Neuroleptic syndrome: Neurological disorder most often caused by adverse reaction to neurotopic or antipsychotic drugs.
[29] Akathesis: Unpleasant side effect involving objective and subjective components. Symptoms include tension, panic, impatience, figety leg movements and shuffling of feet.

intermittently, this may still have been the case, even though her plasma levels[30] were normal, as they could have been much higher a few days before.

- The manufacturers warn in generality that the sedative effects of the antipsychotic and Trazodone may be intensified when prescribed together and that is why Frances may have been using Trazodone for the sedation of it alone and its sedation effect in combination with the Risperidone.

- Trazodone has to be used with caution with antidepressants, antipsychotics and alcohol.

- The undesirable effects of Trazodone are noted in section of the SPC, 4.8 entitled "*Undesirable Effect*s", where it states cases of suicidal ideation and suicidal behaviours have been reported during Trazodone therapy or early after treatment discontinuation.

  The side effects noted in relation to psychiatric disorders and central nervous system disorders are:

  **Psychiatric disorders**
  Suicidal ideation or suicidal behaviours; Confusional state; Insomnia; Disorientation; Mania; Anxiety; Nervousness; Agitation (very occasionally exacerbating to delirium); Delusion; Aggressive reaction; Hallucinations; Nightmares; Libido decreased; Withdrawal syndrome.

  **Nervous system disorders**
  Serotonin syndrome; Convulsion; Neuroleptic malignant syndrome; Dizziness; Vertigo; Headache; Drowsiness; Restlessness; Decreased alertness; Tremor; Blurred vision; Memory; Disturbance; Myoclonus; Expressive aphasia; Paraesthesia; Dystonia; Taste altered.

- It should be noted that all the side effects listed above are likely to have, or possibly worsen with Fluoxetine and Risperidone present and are worse at the time when doses and plasma levels are increasing and decreasing.

[30] Plasma levels: Level of substances found in the blood.

- In summary, it may be highly significant that Frances McKeown was abusing Trazodone because of its own effects on suicidality and its own adverse experiences, all of which could have been increased by the prescription of Fluoxetine and Risperidone.

## SECTION 18: RESPONSES TO ISSUES OF CONCERN

### The South Eastern Health and Social Care Trust

The South Eastern Health and Social Care Trust provided a comprehensive response to the Issues of Concern raised in this report.

The response included the following:

*"The analysis in your report of the factors associated with Frances' death is fair and well considered. The report cogently cites the complexities of her diagnosis of Emotionally Unstable Personality Disorder as defined by the ICD-10 International Classification of Mental and Behavioural Disorders, the on-going stressors relating to not only her legal situation, the untimely death of a friend, relationship difficulties and issues around the degree to which she was likely to be permitted to have a significant role in the care of her children. Clearly any one of the aforementioned stressors would have an adverse effect on any person's, let alone an individual with a confident diagnosis of Emotionally Unstable Personality Disorder's mental wellbeing.*

*A number of issues of concern requiring action have been identified in the report. Much work has already been undertaken by the Trust to learn the lessons from Frances' untimely death. Specifically the Mental Health service and Governance arrangements have been significantly improved in the following ways:*

- *A Mental Health nurse has now been allocated to Hydebank Wood to provide mental health support/interventions for women prisoners.*

- *A Mental Health Team has been established to service the three prison sites. This team uses a stepped care model in line with NICE guidance for the provision of mental health services. This model ensures that the least intensive intervention that is appropriate for a person is typically provided first and people can step up or down the pathway according to changing needs and in response to treatment. For Prison Healthcare this has meant developing services for the mental health team to provide:*

- *Support for mild mental health difficulties based on the 'living well behind the door' stress pack.*

- *Moderate to severe mental health care with a full mental health assessment, Key Worker, Cognitive Behaviour Therapy and wellness recovery action planning which aims to enable patients to use their time effectively within prison and prepare/plan for life within the community.*

- *Psychiatrist assessment and treatment planning for patients with severe mental illness.*

- *This team now employs two Mental Health nurses and one Forensic Occupational Therapist at Hydebank Wood. In addition the forensic psychiatrists and "addiction" staff assess patients in an appropriate and timely way. The team is fully staffed at Hydebank Wood with no current vacancies.*

- *Referral pathways are now in place for all mental health referrals. Referrals are accepted from Doctors, Nurses and Occupational Therapists. This is reflective of services provided in the community to similar groups of clients. All referrals are sent to a central location in the healthcare unit. These are then discussed and allocated appropriately at the weekly multidisciplinary team meeting.*

- *Clear referral criteria to the mental health team have been developed. Referrals are accepted in the following circumstances:*

  - *Diagnosis of a severe/enduring mental illness.*

  - *Contact with a Community Mental Health Team prior to committal, Child/Adolescent Mental Health or Drug Alcohol Mental Health Service.*

  - *Recent psychiatric hospital admission.*

  - *Changes in presentation (mood, sleep, appetite, behaviour) exhibiting mental distress for a period of over two weeks.*

- *Deliberate self harm related to a disturbed mental state. This includes referrals generated by the appropriate triggers of the SPAR documentation process.*

- *Weekly Multidisciplinary Team meetings are now held where referrals, assessment, treatment plans, interventions and caseloads are discussed and allocated to the appropriate mental health professional.*

- *It is clear that the committals process was not as robust as it could have been. The Trust is currently taking forward work to improve the committals process utilising LEAN™[31] service improvement methodology. The need for a new dedicated committal team has been identified and agreed. The new committals team will have additional training to ensure that the healthcare needs of all people committed to prison are assessed in a timely, effectively and appropriate manner. In the meantime the Trust has put in place advice to staff and audit arrangements to ensure the service is improved. Processes are now in place to access and review patient notes from the community. This process is now audited on a regular basis with the last audit reporting a 93% compliance rate. The reason for the 7% non compliance was due to GPs not replying within the requested time frame. Actions to address this are now in place.*

- *A new management team is now in place in Hydebank Wood. This team have made monitoring nursing practice and competence a priority. The reforms outlined above have addressed several of the issues of concern identified in your report. These include taking account of patient's psychiatric history prior to committal to custody, actioning of psychiatric referrals, clarity around the target timescales for referrals and improving multidisciplinary work to support people in prison with mental ill health. These steps will be strengthened when the Trust has access to the Electronic Care System (ECS) which is expected to be implemented in 2013. In the meantime the current practice of Healthcare staff phoning the community GP for current medication on committal will be maintained and monitored.*

[31] Lean Enterprise Institute™ is an organisation which provides service improvement methodology.

- *In your report you identify that Frances was able to abuse her medication and access non-prescribed medication. Each patient is individually assessed for the appropriateness of being able to look after their own medication. Since Frances' death the assessment document for in-possession medication has been reviewed in order to assist staff to make better decisions about Prisoners holding their medication in their own possession. This will contribute to reducing the volume of prescribed medication circulating in prisons and inappropriate trading in medication between prisoners. The Trust welcomes further work being undertaken by the Northern Ireland Prison Service (NIPS) to tackle the supply of illicit drugs and non prescribed medication obtained from other sources. The Trust is actively working with the NIPS to tackle the issue of abuse of prescribed medication. Arrangements for observed administration of the top five tradable/abusable drugs have been successfully implemented in Hydebank Wood in recent months.*

- *You refer in your report to Trust Nursing staff stating that response bags contain too much equipment, some of which is not necessary. All staff had been issued with guidance on what the bags should contain and how to do the weekly checking of same. It would appear that the nurses were ensuring that every medical emergency would be catered for when in effect, in Code Blue situations, the only equipment needed is airway equipment, oxygen and a defibrillator. The emergency bags have been reviewed and unnecessary items removed. Nurses have also been reminded of the importance of adhering to this policy. This is important as it is necessary to manually carry the equipment as it is not possible to provide a trolley because of the terrain and the need to use stairs to access certain areas".*

*The Trust also said the following:*

*The outworking of the Borderline Personality Construct and the need to comprehensively coordinate the multiplicity of possible interventions liable to be offered in such a future case are so complex and resource intensive that they raise fundamental questions about the care and treatment of such similar patients in a custodial setting including:*

a) *Is it still appropriate to continue to admit females with longstanding characterological disturbance (and hence an inherent propensity to suicidality) to a prison environment within and outwith clinicians have little control over significant aversive factors yet are deemed to have ultimate clinical responsibility?*

b) *If no viable alternatives are provided for future prisoners with similar difficulties to Frances what care/management strategies need to be provided and co-ordinated to avoid future tragedies?*

Clearly the answer to these questions would have a broad resonance and implications for the Criminal Justice System and Healthcare provision. They are not matters for the South Eastern Trust alone. I am happy to provide the assurance that the Trust will continue to improve the healthcare service to those in custody in our Prisons within the resource made available to us. Nevertheless these improvements will not necessarily prevent a similar death unless the questions above are considered and addressed. The Trust will ensure that these questions are considered with the Department of Health, Social Services & Public Safety and with the Health and Social Care Board as there will be a need for inter-agency support and commitment to address these issues.

**Northern Ireland Prison Service**

The Northern Ireland Prison Service also provided an Action Plan in response to the Issues of Concern raised in this report. The response is available on the Northern Ireland Prison Service website.

# APPENDICES

**APPENDIX 1**

## PRISONER OMBUDSMAN FOR NORTHERN IRELAND
## TERMS OF REFERENCE FOR INVESTIGATION OF
## DEATHS IN PRISON CUSTODY

1. The Prisoner Ombudsman will investigate the circumstances of the deaths of the following categories of person:

   **Prisoners (including persons held in young offender institutions). This includes persons temporarily absent from the establishment but still in custody (for example, under escort, at court or in hospital). It excludes persons released from custody, whether temporarily or permanently. However, the Ombudsman will have discretion to investigate, to the extent appropriate, cases that raise issues about the care provided by the prison.**

2. The Ombudsman will act on notification of a death from the Prison Service. The Ombudsman will decide on the extent of investigation required depending on the circumstances of the death. For the purposes of the investigation, the Ombudsman's remit will include all relevant matters for which the Prison Service, is responsible, or would be responsible if not contracted for elsewhere. It will therefore include services commissioned by the Prison Service from outside the public sector.

3. The aims of the Ombudsman's investigation will be to:

   - Establish the circumstances and events surrounding the death, especially as regards management of the individual, but including relevant outside factors.
   - Examine whether any change in operational methods, policy, and practice or management arrangements would help prevent a recurrence.
   - In conjunction with the DHSS&PS, where appropriate, examine relevant health issues and assess clinical care.
   - Provide explanations and insight for the bereaved relatives.

- Assist the Coroner's inquest in achieving fulfilment of the investigative obligation arising under article 2 of the European Convention on Human Rights, by ensuring as far as possible that the full facts are brought to light and any relevant failing is exposed, any commendable action or practice is identified, and any lessons from the death are learned.

4. Within that framework, the Ombudsman will set terms of reference for each investigation, which may vary according to the circumstances of the case, and may include other deaths of the categories of person specified in paragraph 1 where a common factor is suggested.

**Clinical Issues**

5. The Ombudsman will be responsible for investigating clinical issues relevant to the death where the healthcare services are commissioned by the Prison Service. The Ombudsman will obtain clinical advice as necessary, and may make efforts to involve the local Health Care Trust in the investigation, if appropriate. Where the healthcare services are commissioned by the DHSS&PS, the DHSS&PS will have the lead responsibility for investigating clinical issues under their existing procedures. The Ombudsman will ensure as far as possible that the Ombudsman's investigation dovetails with that of the DHSS&PS, if appropriate.

**Other Investigations**

6. Investigation by the police will take precedence over the Ombudsman's investigation. If at any time subsequently the Ombudsman forms the view that a criminal investigation should be undertaken, the Ombudsman will alert the police. If at any time the Ombudsman forms the view that a disciplinary investigation should be undertaken by the Prison Service, the Ombudsman will alert the Prison Service. If at any time findings emerge from the Ombudsman's investigation which the Ombudsman considers require immediate action by the Prison Service, the Ombudsman will alert the Prison Service to those findings.

7. The Ombudsman and the Inspectorate of Prisons will work together to ensure that relevant knowledge and expertise is shared, especially in relation to conditions for prisoners and detainees generally.

**Disclosure of Information**

8. Information obtained will be disclosed to the extent necessary to fulfil the aims of the investigation and report, including any follow-up of recommendations, unless the Ombudsman considers that it would be unlawful, or that on balance it would be against the public interest to disclose particular information (for example, in exceptional circumstances of the kind listed in the relevant paragraph of the terms of reference for complaints). For that purpose, the Ombudsman will be able to share information with specialist advisors and with other investigating bodies, such as the DHSS&PS and social services. Before the inquest, the Ombudsman will seek the Coroner's advice regarding disclosure. The Ombudsman will liaise with the police regarding any ongoing criminal investigation.

**Reports of Investigations**

9. The Ombudsman will produce a written report of each investigation which, following consultation with the Coroner where appropriate, the Ombudsman will send to the Prison Service, the Coroner, the family of the deceased and any other persons identified by the Coroner as properly interested persons. The report may include recommendations to the Prison Service and the responses to those recommendations.

10. The Ombudsman will send a draft of the report in advance to the Prison Service, to allow the Service to respond to recommendations and draw attention to any factual inaccuracies or omissions or material that they consider should not be disclosed, and to allow any identifiable staff subject to criticism an opportunity to make representations. The Ombudsman will have discretion to send a draft of the report, in whole or part, in advance to any of the other parties referred to in paragraph 9.

**Review of Reports**

11. The Ombudsman will be able to review the report of an investigation, make further enquiries, and issue a further report and recommendations if the Ombudsman considers it necessary to do so in the light of subsequent information or representations, in particular following the inquest. The Ombudsman will send a proposed published report to the parties referred to in paragraph 9, the Inspectorate of Prisons and the Minister of Justice. If the proposed published report is to be issued before the inquest, the Ombudsman will seek the consent of the Coroner to do so. The Ombudsman will liaise with the police regarding any ongoing criminal investigation.

**Publication of Reports**

12. Taking into account any views of the recipients of the proposed published report regarding publication, and the legal position on data protection and privacy laws, the Ombudsman will publish the report on the Ombudsman's website.

**Follow-up of Recommendations**

13. The Prison Service will provide the Ombudsman with a response indicating the steps to be taken by the Service within set timeframes to deal with the Ombudsman's recommendations. Where that response has not been included in the Ombudsman's report, the Ombudsman may, after consulting the Service as to its suitability, append it to the report at any stage.

**Annual, Other and Special Reports**

14. The Ombudsman may present selected summaries from the year's reports in the Ombudsman's Annual Report to the Minister of Justice. The Ombudsman may also publish material from published reports in other reports.

15. If the Ombudsman considers that the public interest so requires, the Ombudsman may make a special report to the Minister of Justice.

16. Annex 'A' contains a more detailed description of the usual reporting procedure.

**REPORTING PROCEDURE**

1. The Ombudsman completes the investigation.

2. The Ombudsman sends a draft report (including background documents) to the Prison Service.

3. The Service responds within 28 days. The response:
   (a) draws attention to any factual inaccuracies or omissions;
   (b) draws attention to any material the Service consider should not be disclosed;
   (c) includes any comments from identifiable staff criticised in the draft; and
   (d) may include a response to any recommendations in a form suitable for inclusion in the report. (Alternatively, such a response may be provided to the Ombudsman later in the process, within an agreed timeframe).

4. If the Ombudsman considers it necessary (for example, to check other points of factual accuracy or allow other parties an opportunity to respond to findings), the Ombudsman sends the draft in whole or part to one or more of the other parties. (In some cases that could be done simultaneously with step 2, but the need to get point 3 (b) cleared with the Service first may make a consecutive process preferable).

5. The Ombudsman completes the report and consults the Coroner (and the police if criminal investigation is ongoing) about any disclosure issues, interested parties, and timing.

6. The Ombudsman sends the report to the Prison Service, the Coroner, the family of the deceased, and any other persons identified by the Coroner as properly interested persons. At this stage, the report will include disclosable background documents.

7. If necessary in the light of any further information or representations (for example, if significant new evidence emerges at the inquest), the Ombudsman may review the report, make further enquiries, and complete a revised report. If necessary, the revised report goes through steps 2, 3 and 4.

8. The Ombudsman issues a proposed published report to the parties at step 6, the Inspectorate of Prisons and the Minister of Justice. The proposed published report will not include background documents. The proposed published report will be anonymised so as to exclude the names of individuals (although as far as possible with regard to legal obligations of privacy and data protection, job titles and names of establishments will be retained). Other sensitive information in the report may need to be removed or summarised before the report is published. The Ombudsman notifies the recipients of the intention to publish the report on the Ombudsman's website after 28 days, subject to any objections they may make. If the proposed published report is to be issued before the inquest, the Ombudsman will seek the consent of the Coroner to do so.

9. The Ombudsman publishes the report on the website. (Hard copies will be available on request). If objections are made to publication, the Ombudsman will decide whether full, limited or no publication should proceed, seeking legal advice if necessary.

10. Where the Prison Service has produced a response to recommendations which has not been included in the report, the Ombudsman may, after consulting the Service as to its suitability, append that to the report at any stage.

11. The Ombudsman may present selected summaries from the year's reports in the Ombudsman's Annual Report to the Minister of Justice. The Ombudsman may also publish material from published reports in other reports.

12. If the Ombudsman considers that the public interest so requires, the Ombudsman may make a special report to the Minister of Justice. In that case, steps 8 to 11 may be modified.

13. Any part of the procedure may be modified to take account of the needs of the inquest and of any criminal investigation/proceedings.

14. The Ombudsman will have discretion to modify the procedure to suit the special needs of particular cases.

**APPENDIX 2**

# INVESTIGATION METHODOLOGY

## Notification

11. On the evening of Wednesday 4 May 2011, the Prisoner Ombudsman's office was notified by the Northern Ireland Prison Service about Frances' death in Hydebank Wood Women's Prison.

12. A member of the Ombudsman's investigation team attended Hydebank Wood Women's Prison that evening to be briefed about the series of events leading up to Frances' death.

## Notices to Prisoners/Inmates

13. On 5 May 2011, Notices of Investigation were issued to Prison Service Headquarters and to staff and inmates at Hydebank Wood Women's Prison and Young Offenders Centre announcing the Prisoner Ombudsman's investigation and inviting anyone with information relating to Frances' death to contact the Investigation Team.

## Prison Records and Interviews

14. All of the prison and prison healthcare records relating to Frances' period of custody were obtained.

15. Interviews were carried out with prison management, staff and inmates, in order to obtain information about the circumstances surrounding Frances' death.

**Telephone Calls**

16. Records show that Frances made 25 telephone calls between 8 February (the earliest date for which calls were still available) and 4 May 2011. Recordings of these calls were obtained.

**CCTV Footage**

17. CCTV cameras are not situated on the landing where Frances was located; however, CCTV from the recreation/dining room and landing circle[32], on occasions shows Frances' movements to and from the landing.

**Autopsy & Toxicology Report**

18. The investigation team liaised with the Coroners Service for Northern Ireland and were provided with the autopsy and toxicology report.

**Clinical Review**

19. As part of the investigation into Frances' death, a clinical review was commissioned to examine Frances' healthcare needs and the medical treatment she received in Hydebank Wood.

20. I am grateful to Dr Seena Fazel, Consultant Forensic Psychiatrist and Clinical Senior Lecturer in Forensic Psychiatry at the University of Oxford, who carried out the clinical review.

21. Dr Fazel's clinical review report was forwarded to the South Eastern Health and Social Care Trust for comment. The Trust responded and I have included the comments made at the appropriate places in this report.

[32] Landing Circle – A reception type area where staff are located to monitor all movement to and from the landing and recreation/dining room.

22. Dr Malcolm VandenBurg, a specialist in General Medicine and Consultant Pharmaceutical Physician also assisted with some specific queries relating to Frances' medication.

**Factual Accuracy Check**

23. Before completing the investigation I submitted the draft report to the Director General of the Northern Ireland Prison Service and the Director of Adult Services and Prison Health for the South Eastern Health and Social Care Trust for a factual accuracy check.

24. The Prison Service and Trust responded with their comments for my consideration.

25. I have fully considered these comments and made amendments where I felt that this was appropriate.

**APPENDIX 3**

## HYDEBANK WOOD WOMENS PRISON AND YOUNG OFFENDERS CENTRE

### Background Information

Hydebank Wood Prison and Young Offenders Centre is a medium to low security establishment located in South Belfast which accommodates all young male Offenders aged between 17 and 21 years on conviction, serving a period of 4 years or less in custody and all female prisoners including young Offenders.

The Centre was opened in 1979, and has the capacity to hold up to 306 inmates (both remand and sentenced.) It comprises five self-contained houses – Elm, Willow, Cedar, Beech and Ash. Although some services are shared, Ash House has been designated, since 2004, as the women's prison, and it has a distinct and separate identity. Each of the five houses can accommodate approximately 60 inmates in single cell accommodation.

Arrangements can be made to accommodate younger people at Hydebank Wood. Legislation also permits inmates of 15 years old to be held in Hydebank Wood if their crime is deemed to be of a very serious nature. Male juvenile inmates are accommodated separately on two landings within Willow house (Hydebank Wood does not accommodate female juveniles, who are, instead, held at the Juvenile Justice Centre in Bangor.)

It is one of three detention establishments managed by the Northern Ireland Prison Service, the others being Maghaberry Prison and Magilligan Prison.

The regime in Hydebank Wood aims to focus on a balance between appropriate levels of security and the Healthy Prisons Agenda[33]– safety,

[33] Healthy Prisons Agenda – The concept of a healthy prison is one that was first set out by the World Health Organisation, but it has been developed by HM Inspectorate of Prisons. It is now widely accepted as a definition of what ought to be provided in any custodial environment.

respect, constructive activity and addressing offending behaviour. Purposeful activity and offending behaviour programmes are a critical part of the resettlement process. In seeking to bring about positive change, staff develop prisoners/inmates through a Progressive Regimes and Earned Privileges Scheme (PREPS) as in other prisons.

**APPENDIX 4**

## POLICIES AND PRISON RULES

The following is a summary of Prison Service policies and procedures relevant to this investigation. They are available from the Prisoner Ombudsman's Office on request.

### Prison Rules

**Rule 80 of The Prison and Young Offender's Centres Rules (Northern Ireland) 1995** states that at every prison a separate building or a suitable part of the prison shall be equipped, furnished and staffed in a way appropriate to the **health care** and treatment of sick prisoners.

**Rule 85 (2A) TO 85 (2C) of The Prison and Young Offender's Centres Rules (Northern Ireland) 1995** sets out the provisions of certain functions of the medical officer to be carried out by a registered nurse.

**Rule 88A (1) of The Prison and Young Offender's Centres Rules (Northern Ireland) 1995** states that a governor may require that a prisoner whom he considers to be at risk of suicide or self-harm be accommodated in a cell or room designated for the management of that prisoner's risk of suicide or self-harm.

**Rule 88A (2) of The Prison and Young Offender's Centres Rules (Northern Ireland) 1995** Where the cell or room designated under paragraph (1) is an observation cell the prisoner shall be accommodated in that cell for such period as is consistent with the management of his risk of suicide or self-harm.

### Death in Custody Contingency Plan

**The Death in Custody Contingency Plan** provides step by step guidance for all staff in how to deal with and manage the death of a prisoner in custody.

**Prison Service Policies**

**Self Harm and Suicide Prevention Policy (February 2011)** The Prison Service Self-Harm and Suicide Prevention policy updated and re-issued in February 2011 states that it:

*"aims to identify prisoners at risk of suicide or self harm and provide the necessary support and care to minimise the harm an individual may cause to him or herself. The Service recognises that this is an important priority and one that demands a holistic approach. Prisoners become vulnerable for many reasons. Vulnerability is often presented as an inability to cope with personal situations and/or the prison environment and where, without some form of intervention the likelihood of self-harm or loss of life is imminent. The Service's definition of a vulnerable prisoner is;*

*'An individual whose inability to cope with personal situations within the prison environment may lead them to self harm. Some at risk prisoners will display their inability to cope through their actions or behaviours or the manner in which they present, others may give little or no indication."*

**Governor's Orders**

Governor's Orders are specific to each prison establishment. They are issued by the Governor to provide guidance and instructions to staff in all residential areas on all aspects of managing prisoners. The following orders have been considered as part of this investigation:

**Governor's Order 1-12 'Death of an Inmate'** details to the actions required by staff in the Communication Room, the Duty Governor, staff at the scene and of healthcare staff.

**Governor's Order 11-15 'Attendance at Safer Custody Case Conference Reviews'**, which details representatives required to attend the case review.

**Governor's Order 11-17 'Referrals to Safer custody'** details to how staff should refer an inmate to the Safer Custody team.

**Governor's Order 11-15 'SPAR Process'** advises staff of the SPAR process, how and when this should be implements and the responsibilities of staff who have the duty of care for inmates with an open SPAR booklet.

**Governor's Order 11-24 'Closing a SPAR Booklet'**, which details the actions required before a SPAR booklet can be closed.