

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Baby A at HMP Bronzefield on 27 September 2019

A report by the Prisons and Probation Ombudsman

Our Vision

To carry out independent investigations
to make custody and community
supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*

Respectful: *we are considerate and courteous*

Inclusive: *we value diversity*

Dedicated: *we are determined and focused*

Fair: *we are honest and act with integrity*



© Crown copyright, 2021

This report is licensed under the terms of the Open Government Licence v3.0. To view this licence, visit nationalarchives.gov.uk/doc/open-government-licence/version/3 or email the Copyright Team at psi@nationalarchives.gov.uk

Where we have identified any third-party copyright information you will need to obtain permission from the copyright holders concerned.

When you use this information under the Open Government Licence, you should include the following attribution: Independent investigation into the death of Baby A at HMP Bronzefield on 27 September 2019, Prisons and Probation Ombudsman, 22nd September 2021, licensed under the Open Government Licence.

The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

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

On 9 October 2019, I was asked by the Secretary of State for Justice to undertake a special investigation into the death of Baby A at HMP Bronzefield on 27 September 2019. My investigation has been delayed by for a number of reasons, including a police investigation and the national prison lockdown in response to the COVID-19 pandemic, which prevented the investigator from meeting Baby A's mother, Ms A. Hearing Ms A's experience directly was a crucial part of this investigation. I am grateful to her for sharing her experience and contributing to the significant learning that will come out of it.

Wide terms of reference allowed me to examine in detail the part played by every different agency involved in Ms A's maternity care. My investigation identified a considerable number of issues and concerns about the care and management of Ms A. I make a significant number of recommendations to improve maternity services in Bronzefield.

There is wider learning for the whole of the women's prison estate from the death of Baby A, and the Prison Service must take this opportunity to improve the outcomes for pregnant prisoners so that this tragic event is not repeated.

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

Sue McAllister CB
Prisons and Probation Ombudsman

September 2021

Contents

Summary	1
The Investigation Process	6
Background Information	8
Key Events	10
Findings.....	24
Terms of Reference.....	41
Annex 3: Clinical Recommendations	43

Summary

Events

1. On 4 December 2018, Ms A was allocated a social worker by Camden Safeguarding and Social Work (CSSW). On 28 February 2019, Ms A took a pregnancy test in police custody that indicated she was pregnant, giving an estimated delivery date (EDD) of between 6 September and 6 October. A second social worker was appointed for her unborn baby (Baby A).
2. Ms A refused all maternity care in the community and was thought to be misusing alcohol and drugs. In July 2019, Baby A's due date was estimated as 21 November based on visual assessment at University College London Hospital (UCLH). Later the same month a child protection plan was put in place for Baby A.
3. On 14 August 2019, Ms A was remanded to HMP Bronzefield. On 19 August, one of the safeguarding midwives from Ashford St Peter's Hospital (ASPH) measured Baby A's foetal growth as 32 centimetres (symphysis fundal height), suggesting that Ms A was 32 weeks pregnant. This would have given an EDD of 24 September to 14 October, but the midwife did not recalculate the due date from the November estimate.
4. Ms A engaged minimally or not at all with the ASPH midwife team and all antenatal care, including refusing to attend appointments for scans.
5. On 6 September, Ms A was placed on Bronzefield's clinical complex case ledger – a list of prisoners that require daily measurement of their baseline observations and weekly appointments with a GP.
6. On 25 September, Ms A told a nurse that she would kill herself or someone else if her baby was taken from her after birth. The nurse told an officer on duty who discussed what Ms A had said with Ms A. Neither the nurse nor the officer considered it necessary to begin Prison Service suicide and self-harm monitoring, known as ACCT.
7. On 26 September, Ms A was put on 'extended observations' by the deputy head of healthcare. This meant she should have been checked by a nurse every morning, afternoon and evening and a minimum of twice during the night, but this did not happen.
8. Ms A rang her cell bell at 8.07pm that evening and asked for a nurse, although she did not say why. The officer who took the call handed over the information to a colleague before attending an incident on another house block. The second officer spoke to Ms A on the cell call system but cannot remember the conversation. No nurse was called for Ms A.
9. Ms A pressed her cell bell again at 8.32pm. The call was not answered on the house block and was diverted to the permanently staffed communications room. At 8.45pm the call was connected and immediately disconnected. Ms A did not press her cell bell again.

10. At 9.27pm and 4.19am, Ms A's cell was checked as part of a routine roll count but neither of the officers who did the check noticed anything untoward in her cell.
11. At 8.21am on 27 September, two prisoners alerted wing staff to blood in Ms A's cell. An officer investigated and discovered that Ms A had given birth during the night. Nurses attempted to resuscitate Baby A and called an ambulance. At 9.03am, paramedics confirmed Baby A had died.
12. Ms A was taken by ambulance to ASPH and returned to the prison that evening. She was placed in the prison's inpatients unit on constant observations and ACCT monitoring for three days until she was released from prison on bail on 17 October.
13. The pathologist was unable to determine whether Baby A was born alive or was stillborn.

Findings

Ms A's care

14. Ms A gave birth alone in her cell overnight without medical assistance. This should never have happened. Overall, the healthcare offered to Ms A in Bronzefield was not equivalent to that she could have expected in the community.
15. Information sharing within the prison and health agencies was poor and the approach to managing Ms A in Bronzefield was uncoordinated.
16. No one responsible for Ms A's care had a full history of her pregnancy. None of the multiple record systems involved spoke to each other, none of the separate records contained sufficient information on their own for proper oversight and no one person had access to them all.
17. Ms A was a vulnerable young woman with a complex history who found it difficult to trust people in authority. She was afraid (with reason) that her baby would be taken away from her immediately after birth and she refused to engage with maternity services. She was a challenging person to manage but we found that the midwives' approach to her care was inflexible, unimaginative and insufficiently trauma-informed and that there was no plan for dealing with a pregnant woman who refused to accept the usual procedures (which focussed on her baby rather than on her).
18. Prison healthcare staff were not sufficiently involved in maternity care in general and in Ms A's maternity care specifically.
19. Maternity services at Bronzefield were outdated and inadequate. There was insufficient oversight of the midwifery team by ASPH.
20. The midwife-centric model of maternity care in the community is not appropriate in a custodial setting.
21. There was a lack of clarity about Ms A's estimated delivery date. It should have been calculated using the only clinical information available, which was gathered

on 19 August and which gave an EDD of 24 September to 14 October, but was instead recorded as being likely to be in November.

22. In the days leading up to Baby A's birth there were several missed opportunities to increase observations on Ms A that might have led to her labour being discovered. We consider that the nurse and officer who spoke to Ms A on 25 September should have begun suicide and self-harm monitoring procedures (ACCT) after she said she would kill herself or someone else if her baby was taken away. We are also concerned that extended clinical observations did not take place as planned.
23. Staff working on Ms A's house block on 26/27 September did not know that Ms A might give birth imminently.
24. The response to Ms A's request for a nurse on 26 September was completely inadequate.
25. An ambulance was not called promptly in response to two medical emergency codes on 27 September.
26. There was no paediatric or neonatal emergency equipment in the prison and no staff were trained in neonatal resuscitation.
27. The multi-disciplinary support plan developed for Ms A by healthcare and psychology after the death of Baby A, was clear and identified appropriate issues and support.

Wider findings

28. We consider that all pregnancies in prison should be treated as high risk by virtue of the fact that the woman is locked behind a door for a significant amount of time. In addition, there is likely to be a higher percentage of 'avoidant' mothers who have experienced trauma and who are fearful of engaging with maternity care. We therefore consider that effective oversight of pregnant women in prison requires that:
 - there is a clear perinatal pathway;
 - the midwifery service is integrated with healthcare;
 - healthcare staff have clinical expertise with pregnant women;
 - the midwifery service is tailored to the specific needs of pregnant women in a custodial setting; and
 - care is able to take account of women who do not want to engage with maternity and healthcare services.
29. The investigation also made significant incidental findings about the management of child death procedures, healthcare for babies and children in the mother and baby unit (MBU), and child safeguarding.

Recommendations

- The Director of Health and Justice for NHS England should consider the findings and recommendations in this report and ensure that the learning is applied across the women's estate. This should include recognition that:
 - the clinic-based community model of midwifery care is not appropriate to a custodial setting; and
 - all pregnancies in prison are high risk.
- The Director of Bronzefield, the SJS Healthcare Manager, the Head of Healthcare at Bronzefield, the Health and Justice Commissioning Lead for the NHS Surrey Heartlands Clinical Commissioning Group, and the Director of Midwifery at Ashford and St Peter's Hospitals NHS Foundation Trust (ASPH) should:
 - work together to urgently re-profile and update the maternity service provision at Bronzefield to reflect the increased demand since the closure of HMP Holloway; and
 - ensure that the maternity service is sufficiently resourced to provide:
 - an appropriately qualified midwifery lead to oversee all aspects of perinatal care;
 - the development of a maternity pathway for prisoners that includes a process for those women who decline to engage with services and access to psychological and psychiatric services for support;
 - a forum for everyone that provides clinical care to pregnant women to discuss individual cases and that relevant discussion is recorded in SystmOne;
 - remote access for the ASPH midwives to SystmOne;
 - training in trauma-informed care, recognising early signs of labour and neonatal and child resuscitation procedures;
 - appropriate emergency resuscitation equipment for children and neonates; and
 - guidance on how to respond to births in prison.
- The SJS Healthcare Manager should establish a clear process for emergency responses to births at Bronzefield to ensure that immediate practical basic assistance can be provided.
- The Director of Bronzefield, the SJS Healthcare Manager and the Director of Midwifery at ASPH should each commission an independently facilitated session for their staff to enable a reflective discussion of this case.
- The Sodexo Healthcare Manager should obtain external expert advice about:
 - the level of training and expertise that should be available in the prison in relation to neonatal and child resuscitation; and

- the resuscitation equipment that should be provided.
- The Head of Custodial Contracts in HM Prison and Probation Service (HMPPS) should write personally to the Ombudsman setting out how they will ensure that the MOJ Controller is able to exercise effective contractual oversight of healthcare services at Bronzefield.
- The Director of Bronzefield, the SJS Healthcare Manager and the Director of Midwifery at ASPH should each commission an independently facilitated session for their staff to enable a reflective discussion of this case.
- The Director of Bronzefield should commission a local investigation into the failure to respond to Ms A's request for a nurse and to answer her cell bell on the night of 26 September 2019 and consider whether disciplinary action is appropriate.
- The Director and Head of Healthcare at Bronzefield should remind all staff of their responsibility to open ACCT procedures if they consider that a prisoner may pose a risk to herself.
- The Head of Healthcare at Bronzefield should share this report with Nurse 3 and discuss the Ombudsman's findings with him.
- The Director of Bronzefield, the SJS Healthcare Manager, the Head of Healthcare at Bronzefield, the Health and Justice Commissioning Lead for the NHS Surrey Heartlands Clinical Commissioning Group, and the Director of Midwifery at ASPH should each address the relevant further recommendations from the clinical review (listed at Annex 3) and should each provide an action plan setting out their response.

The Investigation Process

30. The investigator issued notices to staff and prisoners at HMP Bronzefield informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
31. The investigator obtained copies of relevant extracts from Ms A's prison and medical records. Copies of clinical governance minutes, local policies and minutes of the Maternity Services Liaison Committee were also obtained, together with the two internal investigations carried out by Sodexo.
32. NHS England commissioned Nina Murphy Associates to review Ms A's clinical care at the prison. An independent clinical reviewer undertook the review together with the lead reviewer for the Surrey Child Death Overview Panel.
33. The investigator, independent clinical reviewer and the lead reviewer interviewed 18 members of staff at HMP Bronzefield in January and February 2020. They also met the Acting Director, the Ministry of Justice Controller at the prison, the Sodexo internal investigation team, the Sodexo Healthcare Manager and the Mother and Baby Unit nursery nurse. They attempted to meet the prison's then Head of Healthcare but she did not attend two arranged interviews.
34. The investigator and clinical reviewers interviewed the safeguarding midwives and their line manager at Ashford St Peter's Hospital (ASPH) in January 2020. Due to restrictions in place during the COVID-19 lockdown, further interviews were completed in May, June, July and August 2020 with the consultant obstetrician, a former Bronzefield GP, the current and former health visitor to Bronzefield, and staff from Surrey and Camden Social Services safeguarding teams.
35. Interviews with Surrey and Camden staff were conducted for fact finding purposes and in order to understand Ms A's experience from when her pregnancy was first recorded in February 2019 to when she received bail from Bronzefield in October 2019. These interviews have not been transcribed, but this report has been sent to the relevant teams to inform their own investigations.
36. The investigator and clinical reviewers also spoke to the policy lead in HMPPS's Women's Team responsible for revising Prison Service guidance on Mother and Baby Units, and to Birth Companions (a charity which supports women experiencing severe disadvantage during pregnancy, birth and early parenting). The investigation team also contacted the Nuffield Trust (an independent health think tank) as the Trust's report *Locked out: Prisoner's use of hospital care* was published during the investigation. The clinical review sets out the additional processes and professional sources used to ensure that appropriate clinical standards were applied.
37. The investigators obtained considerable documentation from outside the prison, including Ms A's social services records, Ms A's University College London Hospital (UCLH) records, ASPH board reports, serious incident reports (recorded on Datix) for previous births at Bronzefield, Baby A's Camden social services records and Ms A's community GP records.

38. We informed HM Coroner for Surrey of the investigation and he gave us the results of Baby A's post-mortem examination. We have sent the coroner a copy of this report.
39. The investigator and the lead reviewer kept in contact with Ms A's solicitor throughout the investigation. They met Ms A at the earliest available opportunity, in July 2020, to explain the investigation and to hear about her experience in Bronzefield. We have sent her a copy of this report and discussed it with her in person.

Background Information

HMP/YOI Bronzefield

- 40. HMP/YOI Bronzefield holds adult and young offender women prisoners, including those who have restricted status. It has four house blocks, plus a healthcare unit providing 24-hour care for up to 17 prisoners.
- 41. There is also a Mother and Baby Unit (MBU) providing accommodation for up to 12 prisoners and their babies up to the age of 18 months. This is a separate part of the prison which enables women to have their children with them in prison where appropriate. Women need to apply for entry to the MBU and each application is considered by a board.
- 42. The prison is operated by Sodexo Justice Services (SJS) who provide primary healthcare and integrated substance misuse services. Sodexo directly employs nurses and healthcare assistants and has a corporate contract to employ GPs from Cimarron UK.

HM Inspectorate of Prisons

- 43. The most recent full inspection of Bronzefield was in November and December 2018. Inspectors found a very safe prison with positive staff-prisoner relationships. Health services were well integrated and delivered generally good outcomes. The prison had a comprehensive adult safeguarding policy and there were good links with the local authority.
- 44. Only 50% of prisoners surveyed said their cell call bells were answered within five minutes. Inspectors witnessed bells ringing without a prompt response from staff and some staff ending the calls before prisoners could speak to them or request assistance.
- 45. Pregnant prisoners were referred to midwives for support and links with this service were good. Inspectors considered that antenatal services were of the same standard as those in the community.

Independent Monitoring Board

- 46. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to 31 July 2019, the IMB noted there was a severe shortage of nurses that reflected the national shortage. They did not comment specifically on maternity services.

Previous births at HMP Bronzefield

- 47. There have been two previous unexpected births at Bronzefield, one in October 2017 and one in March 2019. Both babies were delivered by prison nurses in the prisoner's cell. The baby born in October 2017 required neonatal intensive care in hospital but survived. In addition, in December 2017, a full-term stillborn baby was born in an ambulance on the way to hospital. We found some similarities across these cases with the birth of Baby A.

Maternity services at Bronzefield

48. We were unable to identify with any clarity the commissioning arrangements for the maternity service at Bronzefield. At the time of the investigation midwives from Ashford and St Peter's Hospitals NHS Trust (ASPH) attended the prison twice a week on Tuesday and Thursday mornings to provide a midwifery antenatal clinic. A consultant obstetrician, who provided direct clinical service and medical leadership, was allocated 32 hours a year to deliver the service and held eight clinics a year at the prison. Sonographers from ASPH also attended fortnightly and the prison had scanning equipment.
49. We were unable to find a current contract or service level agreement which sets out the resource or the performance and contract management arrangements with Bronzefield.

SystmOne and NOMIS

50. SystmOne is a multidisciplinary electronic patient record that is in use throughout the prison estate and immigration detention accommodation in England and Wales. All clinical staff either employed by the prison or working for another organisation and providing healthcare services are expected to record information in the SystmOne record. They may also be required to make records in the systems of their employing organisations. For example, the visiting midwives at HMP Bronzefield write their records in BadgerNet (an online system for maternity records used by many NHS services) which prison healthcare staff do not have access to.
51. Non-clinical staff do not have access to SystmOne. Prison staff make records on NOMIS (the prisoner's electronic prison records) which prison healthcare staff (but not ASPH staff) have access to.

Gestation calculator

52. A simple gestation calculator, commonly known as a pregnancy wheel, allows people to follow the same steps that a midwife or GP would follow to determine the date of a pregnancy and all the important pregnancy milestones. A full-term pregnancy is considered to be anywhere between 37 - 42 weeks.

ACCT

53. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Key Events

54. Ms A had a traumatic childhood and was known to local authority Children's Services from birth. A review of her engagement with services concluded that years of trauma meant she struggled to form relationships of trust with agencies attempting to engage with her. She had a history of alcohol and substance misuse and of offending. In January 2019, aged 18, she was given 'looked after child status' by Camden Social Services and placed in a semi-independent supported housing unit.

Ms A's pregnancy

55. On 28 February 2019, Ms A took a pregnancy test in police custody that indicated she was pregnant. She reported that her last period was in December 2018 (which gave an estimated delivery date (EDD) for her baby of *6 September to 6 October 2019*).
56. In July 2019, Baby A's due date was estimated as *21 November* based on visual assessment at University College London Hospital (UCLH). Later the same month a child protection plan was put in place for Baby A.
57. On 6 March, Ms A refused to allow a nurse from her community health team to examine her during a planned check. Based on a visual observation, the nurse estimated Ms A was four to five months pregnant (giving an EDD around *August*).
58. On 18 March, Ms A told her housing unit key worker that she thought she had miscarried her baby.
59. On 25 March, a strategy review meeting referred to Ms A's statement that her last period was in December 2018. Despite this, the meeting recorded her estimated delivery date as *1 August 2019*. This appears to be in line with the community nurse's visual estimate on 6 March. Camden social services' case notes showed Ms A continued to insist she was no longer pregnant and refused to attend several scans.
60. On 11 April, a child protection conference concluded that Ms A's case should be closed as there was insufficient evidence that she was pregnant.
61. On 25 May, Ms A was found by the police after she had gone missing from her accommodation. She said she was pregnant but that she had not attended any scans and would not attend hospital to give birth. Another referral was made to the Multi-Agency Safeguarding Hub (MASH) and a social worker made further enquiries at several hospitals to establish whether Ms A was pregnant and was known to their service. On 31 May, the safeguarding midwife at University College London Hospital (UCLH) replied that she was under the impression that Ms A had miscarried her baby.
62. On 27 June, Ms A was arrested for robbery and assault. She told police she was five months pregnant, but later denied it. The next day a strategy meeting decided to complete a child and family assessment with a view to holding an initial child protection conference (ICPC). On 3 July, Ms A saw a police medical officer who estimated that she was six months pregnant.

63. On 4 July, Ms A was examined at the maternity unit in the Elizabeth Garrett Anderson Wing of UCLH and, based on a visual assessment, was estimated to be 20 weeks pregnant. This gave an estimated delivery date of *21 November*, assuming a pregnancy of 40 weeks. This information was not sent to Ms A's community GP.
64. On 17 July, the planned child and family assessment raised concerns that Ms A had been drinking heavily and taking drugs during her pregnancy. Her case was progressed straight to an ICPC because of concern for her unborn child.
65. The ICPC took place on 23 July. The minutes showed an estimated delivery date of *November 2019*, although it was noted that the estimate had been based on stomach size and the due date was unclear. The minutes also noted that Ms A's refusal to engage with social services was because she was afraid they would take her baby away. Her hostel manager said Ms A's "fear, despair, worry and stress were evident" when discussing her baby. A London-wide safeguarding midwife alert was sent to hospitals with Ms A's aliases and an estimated delivery date of *November*.
66. The ICPC concluded that the threshold for significant harm had been met and a child protection plan under the category of neglect was recommended. The social worker allocated to unborn Baby A, was told to carry out unannounced and announced home visits at least once every 10-15 working days. Another meeting was planned for 7 August with a midway review planned for 9 September and a case conference scheduled for 10 October.

HMP Bronzefield

14 - 31 August

67. On 14 August 2019, Ms A was remanded to Bronzefield charged with robbery. It was her first time in prison. The nurse in reception noted that Ms A had asthma, a chest infection and looked pregnant. Ms A said she was suffering badly with acid reflux. The nurse said that Ms A was uncooperative and aggressive and she did not, therefore, complete the initial health screen with her. The nurse assessed her as unsuitable to share a cell. Ms A was allocated a cell on the unit for new prisoners with substance misuse issues (D1 landing on House Block 1 - HB1).
68. The next day, Ms A told Nurse 1 during a substance misuse assessment, that she was six months pregnant. Later that morning Dr 1, a locum prison GP, examined her because she had arrived at the prison after the GPs had left the previous day. Dr 1 said Ms A was acutely unwell. He prescribed omeprazole for acid reflux, arranged for her to use a nebuliser for her asthma on HB1 and booked a check-up the next day. Nurse 2 completed the initial health assessment and referred Ms A to the visiting midwife. Ms A said she did not have a community GP.
69. Dr 1 said Ms A seemed much better at her follow up appointment on 16 August. She told him it was not her first pregnancy and that she had not received any ante-natal care for her current pregnancy. Dr 1 said this surprised him, but he could not remember whether he explored this with her. In light of the information,

he completed a midwife referral form and marked the task as urgent. He said this was a standard maternity form from Ashford St Peter's Hospital (ASPH) and had not been adapted for use in prison.

70. Dr 1 established that Ms A did have a community GP, but the records were not requested. The clinical reviewer obtained the community GP records which showed the safeguarding concerns and child protection measures in place for Baby A before Ms A was remanded to Bronzefield. As the community records were not obtained, no one in healthcare at Bronzefield was aware of these events.
71. The same day Ms A told Prison Custody Officer (PCO) 1 from the Offender Management Unit (OMU) that she was pregnant but would not say for how many months. She gave PCO 1 the contact details of her social worker. PCO 1 contacted the social worker and also notified Ms B, an administrator, and Supervising Prison Custody Officer (SPCO) 1 (both from Bronzefield's Mother and Baby Unit – MBU) and the family support worker and prison lead for care leavers.
72. The safeguarding support midwife at ASPH received an email from the safeguarding midwife at UCLH on 16 August, telling her that Ms A had refused ante-natal care in the community and had a history of using alcohol during pregnancy. The UCLH midwife said she thought Ms A's baby might be due in *November*. She did not write that she had estimated Ms A was 20 weeks pregnant on 4 July.
73. The safeguarding support midwife's usual clinic day was Tuesday, but she went to see Ms A especially the next working day, on Monday 19 August, because she knew the Tuesday clinic was already full. She said Ms A appeared relatively happy to talk about herself but was unwilling to answer most questions about her pregnancy. She told her that she already had a child who was "with her family". The safeguarding support midwife took Ms A's blood pressure and listened to the foetal heart rate. A urine test showed a trace of glucose (this might suggest gestational diabetes and, in addition to Ms A's ethnicity, indicated that a glucose tolerance test was needed).
74. The safeguarding support midwife examined Ms A and measured the fundal height (a measurement to determine foetal growth) as 32 centimetres, suggesting that Ms A was about 32 weeks pregnant, giving an EDD range of *24 September to 14 October*. The safeguarding support midwife said that, in the absence of a scan, fundal height was the most reliable evidence on which to calculate Ms A's EDD. She said she did not recalculate the *November* estimate, however, because she hoped Ms A would agree to a scan. She put Ms A on the list for the clinic with the consultant obstetrician three days later.
75. The safeguarding support midwife noted the 32 cm measurement in Ms A's patient record on SystmOne. She added that this was a high-risk pregnancy because Ms A had not received ante-natal care and had reported a history of alcohol and cannabis misuse during pregnancy. She did not record an EDD.
76. The safeguarding support midwife recorded the appointment in more detail on BadgerNet (the electronic record system used by the ASPH midwives). She said

the agreed EDD was *19 November*. We do not know what the safeguarding support midwife based this on – she did not base it on the foetal height measurement - but working backwards it meant she thought Ms A was 26-27 weeks pregnant when she examined her, which was actually in line with the 20 weeks estimate at UCLH on 4 July.

77. The safeguarding support midwife completed a risk assessment, care plan and ante-natal management plan the next day, on 20 August. These were recorded on BadgerNet but not shared with healthcare staff at Bronzefield. Neither the care plan nor the management plan involved prison healthcare.
78. The safeguarding support midwife also emailed Ms B, the MBU administrator at Bronzefield and said that Ms A had told her that she was 27/28 weeks pregnant but that her examination indicated that Ms A was 32 weeks pregnant. She guessed Ms A was somewhere between the two which meant that her baby might be due in “Oct-Nov”. There is no evidence that the information was passed to anyone else in Bronzefield and it contradicts the safeguarding support midwife’s BadgerNet entry that the EDD was 19 November.
79. The social worker visited Ms A the same day. They were joined by SPCO 1 who had already introduced himself to Ms A. (The social worker was on maternity leave during our investigation and was not interviewed.) The social worker gave Ms A a letter informing her of the concerns for her unborn baby and the plan to go to court to protect the baby by removing her from Ms A after birth. Ms A said she did not want to talk about her baby until it arrived on the grounds that, “If you don’t plan for something you cannot be disappointed if those plans change.” The social worker told her that if she waited for the baby to arrive, she would have no choice in whether she could keep it.
80. SPCO 1 said the social worker was very clear with Ms A about what would happen to her baby. He said the social worker spoke a lot about Ms A’s alcohol abuse and breaking the rules at the hostel she had been living in. He said Ms A accused them of only seeing her baby and not seeing her. He said they tried to reassure her that this was not the case. SPCO 1 did not add the information about the plan to remove the baby at birth to Ms A’s NOMIS (prison record) or pass it to healthcare.
81. The social worker emailed PCO 1 in the OMU after the meeting. She said she was “extremely worried” for the unborn baby’s safety should Ms A be released back into the community. She explained the unborn baby was on a child protection plan and so far, Ms A had not co-operated with the plan by attending scans. She attached the minutes from the child protection conference of 23 July. PCO 1 did not share this information with healthcare staff or record it on Ms A’s NOMIS record.
82. The social worker also emailed the minutes of the child protection conference to the safeguarding support midwife. We cannot be certain when the safeguarding support midwife received the email because she did not upload it to BadgerNet until 21 October (after Baby A’s death) and made no entry on SystmOne. (We know she had received it by the time the child protection plan meeting took place on 9 September.) There was therefore no information on SystmOne about the

child protection plan or that Ms A was likely to be separated from her baby after it was born.

83. Ms A attended the consultant obstetrician's clinic as planned on 22 August. The safeguarding support midwife said Ms A "shut down immediately" when the consultant obstetrician tried to talk to her about the dangers of drinking alcohol during pregnancy. Ms A agreed to a foetal dating scan and the safeguarding support midwife arranged one for the following Tuesday, 27 August. Ms A subsequently refused to attend the appointment.
84. On 29 August, the social worker visited Ms A again. The safeguarding support midwife said she had gone to look for Ms A and decided to join their meeting. SPCO 1 was also there. She tried to persuade Ms A to see the sonographer (scanner) who was in the prison that day, but Ms A refused. Ms A objected to the safeguarding support midwife referring to them going for the scan as "we" and emphasised that it was her that was having the scan. The safeguarding support midwife said the social worker asked Ms A if she would ask for help if she went into labour and Ms A replied, "Of course I fucking would."
85. On 30 August, Ms A did not attend a care leavers appointment with the family support worker.

1 – 24 September

86. On 3 September, SPCO 1 escorted Ms A to healthcare to see the safeguarding support midwife for an ad hoc visit. The safeguarding support midwife said she offered Ms A an anti-D prophylaxis injection (a standard treatment for pregnant women with rhesus D negative blood). She said Ms A was verbally abusive and refused to listen to her.
87. The safeguarding support midwife discussed Ms A with the consultant obstetrician afterwards and they decided that in future Ms A should not be seen alone to ensure there was a witness to her refusal of care and advice. There is no record of this plan on SystmOne and prison healthcare were not informed.
88. On 5 September, Ms A told the safeguarding support midwife and Ms C, the named midwife for safeguarding and vulnerable women, to "get away" from her when they tried to talk to her. The safeguarding support midwife raised a safeguarding alert and emailed Bronzefield's generic healthcare inbox. She said Ms A had refused all maternity care including an ultrasound scan and there were concerns about her unborn baby. As it was not clear when Ms A's estimated delivery date was, she advised prison healthcare staff that if Ms A began bleeding or began labour, she must be transferred to ASPH immediately. (This is standard practice for any pregnant woman going into labour in prison.) She also emailed the social worker to update her. At interview, Ms C said her primary concern was that Ms A might give birth alone. This concern was not shared with any prison staff.
89. As a result of the email, Ms A was added to the clinical 'complex case ledger' the next day, 6 September. There was no formal guidance for this process at the time, but the generally accepted practice was that patients on the ledger would

have their baseline observations taken daily by a nurse and have a weekly appointment with the GP.

90. Also on 6 September, Ms A attended the blood-borne virus clinic with a sexual health nurse. The sexual health nurse said Ms A told her she was not accepting maternity services because the midwives got on her nerves and her baby would be taken away after birth. Ms A said she thought she was seven months pregnant. She said she did not want to attend any of the groups for pregnant women because she did not want to mix with women who would be excited about their babies. The sexual health nurse said Ms A was sad and angry that her baby would be taken from her.
91. The sexual health nurse bumped into the safeguarding support midwife later that day and told her that she had got on well with Ms A. The safeguarding support midwife asked her to help persuade Ms A to have a scan. The sexual health nurse said she subsequently tried to see Ms A on a couple of occasions, but Ms A was always away from the wing.
92. On 9 September, the safeguarding support midwife and Ms C provided evidence for the scheduled child protection plan midway meeting with the UCLH safeguarding midwife. They did not attend the meeting but communicated with the UCLH midwife who did do so. They told her that their best guess was that Ms A was 30-35 weeks pregnant. (This was three weeks after Ms A had told the safeguarding support midwife that she was 27-28 weeks pregnant. The safeguarding support midwife's measurement of 32cm on 19 August, would have meant Ms A was 35 weeks pregnant by 9 September and that the baby might arrive any time between *24 September and 14 October*.) This information was not recorded on Ms A's patient record on SystmOne.
93. On 10 September, Ms A refused to see the social worker. The safeguarding support midwife and Ms C also tried to see Ms A the same day. The safeguarding support midwife said she was about to go on leave and wanted to have a plan in place. They saw Ms A in the education department, but she refused to talk to them and told them repeatedly to go away. The safeguarding support midwife emailed the sonographer to remind her to chase Ms A for a scan, but the sonographer did not read the email before going to the prison. The scan was re-booked for 26 September.
94. Ms A continued to have the daily nursing checks required by the complex case ledger, but these checks did not include anything relating to her pregnancy (such as checking the movement of the baby).
95. On 16 September, Ms A refused to go to an appointment at ASPH. She did not give a reason. Ms A saw Nurse 3 on 18 September for her complex case ledger check. Her pulse was raised but it was not re-checked later as it should have been. Later the same day, Ms A's education tutor became concerned that she was under the influence of an illicit substance. A security information report was completed, and the substance misuse recovery service was contacted, but the information was not passed to healthcare and Ms A was not examined by a nurse.

96. Ms A saw Nurse 3 again on 19 September for her complex case ledger check. Her baseline observations were not in the normal range and her pulse was 119 beats per minute which is significantly raised. Nurse 3 did not re-check her pulse, as he should have done.
97. Bronzefield's Maternity Services Liaison Committee (MSLC) met that afternoon. They discussed Ms A and decided to refer her to the mental health in-reach team. This decision is not recorded on SystmOne and there is no evidence that a referral was made before Baby A was born.
98. On 20 September, the family support worker met Ms A at their rearranged appointment. The family support worker said she was concerned that Ms A was detached from her pregnancy. She emailed SPCO 1 and PCO 1 after the meeting and told them she thought Ms A was very scared about her pregnancy and was "completely lost" and did not know what to do. She said Ms A had told her that there was no point to her attending scans because her baby was going to be taken away from her. The family support worker said she was worried Ms A might give birth alone because she did not want anyone to take the baby away. She told Ms A how she planned to support her going forward and Ms A agreed to see her once a week. This information was not shared with healthcare staff.
99. No complex case ledger checks were completed on 20, 21 or 22 September. On 23 September, a nurse referred Ms A to the GP for shakes in her hands. On 24 September, Ms A did not have a complex case ledger check because the nurse was told, incorrectly, that she was at court.

Wednesday 25 September

100. The prison manager responsible for healthcare, said she added Ms A to the agenda of the weekly care plan meeting on 25 September after SPCO 1 raised concerns about her. SPCO 1 said he was principally concerned that Ms A would not alert staff if she went into labour, so they discussed whether to move Ms A to the inpatient unit for closer observation.
101. The prison manager said that she understood that Ms A's baby could be born at any time because no one knew the estimated delivery date. She said moving Ms A to the inpatient unit was the last resort because it was not a suitable environment for a woman in the late stages of pregnancy. She said she would not have considered moving Ms A at all had she not thought the baby could be born imminently.
102. The inpatient unit was full so they decided that, if Ms A did not attend the sonographer's clinic for a scan the next day, she would move to the next available bed there. No plan was made in the event that Ms A refused to move to the inpatient unit.
103. SPCO 2, the HB1 senior officer, told the meeting that she had a good relationship with Ms A and would encourage her to go for the scan. (We were unable to interview SPCO 2 because she was absent on sick leave. Information about her involvement has been taken from the Sodexo investigation.) The minutes of this meeting were not added to SystmOne until 28 September (after Baby A's death).

104. Ms A's keyworker spoke to Ms A with the family support worker for a regular keywork session. The family support worker said she asked to go along to the keywork session because Ms A had not turned up to her first weekly appointment with her. The family support worker said Ms A was different to how she had been on 20 September and was a "closed book". She tried to give her advice about attending perinatal appointments, but Ms A looked down and did not respond. She looked heavily pregnant and her bump was low indicating to the family support worker that she was close to giving birth.
105. Nurse 3 spoke to Ms A that afternoon after it was reported to him that she was tearful. Ms A told him that SPCO 2 and her education tutor had told her that her baby would be taken from her after birth. She said she would kill herself or someone else if that happened. (Nurse 3 recorded this conversation at 6.17pm and Ms A attended education between 3.30pm and 4.45pm so it appears that the conversation took place after the education class. The education tutor told the Sodexo investigators that she had not said this to Ms A.)
106. Nurse 3 said that the usual procedure when someone said they would harm themselves was to begin ACCT monitoring. He said he did not do this because he thought Ms A was already being monitored and she told him that she had no current thoughts of suicide or self-harm. He said he told HB1 staff and informed the healthcare shift leader. His entry in the medical record recorded that the HB1 SPCO (SPCO 2) would see Ms A the next day.
107. PCO 2 wrote in the HB1 unit observations book:
- "Ms A has said if the baby is taken from her when she goes to hospital, she will self-harm but has stated she does not want to go on an ACCT as nothing will happen to her until the baby is taken from her. Midwife informed."
108. PCO 2 told the investigator that he had discussed starting ACCT monitoring with Ms A but she became agitated at the prospect and he did not want to cause her stress. She was adamant she would only self-harm if her baby was taken from her in hospital. He did not think Ms A was due to give birth for a few months so he thought ACCT monitoring was not immediately necessary. He said he did not know how pregnant Ms A was, but she did not look heavily pregnant, so he guessed about seven months. As far as we are aware, none of the midwives were in the prison that day.

Thursday 26 September

109. The prison manager said she briefed the operational morning meeting that Ms A would move to the inpatient unit if she did not attend the sonographer's clinic that morning. The deputy Head of Healthcare requested that Ms A was put on 'extended observations'. This meant that, in addition to being on the complex case ledger, she would see a nurse each morning, afternoon and evening, and a minimum of twice overnight. According to the Sodexo report, an unnamed nurse was tasked with going to HB1 to tell the nurse based there that Ms A was to be put on extended observations with immediate effect. There is no evidence that this happened, and no extended observations took place. Neither we nor Sodexo have been able to identify this nurse.

110. SPCO 2 told the Sodexo investigation that she had attempted to persuade Ms A to go to the sonographer's clinic for a scan. She said she told Ms A that she was putting her own health at risk as well as that of the baby. SPCO 2 said Ms A repeatedly refused to go to the clinic but would not give a reason why. She told SPCO 1 and the safeguarding support midwife that Ms A had refused her scan.
111. Also that morning, SPCO 1 met the safeguarding support midwife and Ms C to discuss another pregnant prisoner. They discussed Ms A briefly. Ms C said she was very keen for Ms A to be moved to the prison inpatient unit. SPCO 1 went to see Ms A and told her that if she did not go for a scan she would be moved to the inpatient unit. Ms A said she would not go to the inpatient unit. SPCO 1 decided that it was not appropriate for Ms A to be taken there by force, so she remained on HB1.
112. The safeguarding support midwife said, after the clinic finished, she went to HB1 to find Ms A but Ms A would not let her into her cell and told her to go away. Ms A told the investigator that she had not liked the approach of the midwives. She said she found them too nosey and intrusive. She did not feel that they had her interests at heart but were only interested in her baby. The safeguarding support midwife discussed Ms A with the consultant obstetrician when she returned to ASPH.
113. At 7.06pm, the safeguarding support midwife emailed SPCO 1, the family support worker and the generic Bronzefield healthcare inbox. She said that Ms A's estimated delivery date remained unknown although Ms A said she was due in *November*. The safeguarding support midwife said she thought Ms A was somewhere between 31-35 weeks gestation. (This estimate was the same as the one she had conveyed to the UCLH midwife on 9 September, two weeks earlier.) She asked that staff continue to monitor Ms A closely and encourage her to engage with maternity services.
114. A clinical nurse manager replied at 7.49pm to acknowledge receipt of the email and said she had asked for Ms A to be moved to the inpatient unit the next morning for closer monitoring. The clinical nurse manager does not appear to have been aware that this option had already been explored and abandoned.

Night of Thursday 26 September – Friday 27 September

115. PCO 3 and PCO 4 were on duty on HB1 that evening. PCO 4 was not at work when interviews took place and his account is taken from the Sodexo investigation. PCO 4 said at 8.07pm he answered a cell call (an internal telephone call) from Ms A who said, "Get me a fucking nurse." PCO 4 said he asked her why she needed one, but she would not tell him. He said he did not know Ms A. She was rude and abusive and did not sound in distress. The call lasted for one minute five seconds.
116. PCO 4 said he took another cell call immediately afterwards from a prisoner asking for a Listener (a prisoner trained by the Samaritans to provide confidential peer support). The cell call record confirmed the second call came in while PCO 4 was speaking to Ms A. (The call system queues calls and then automatically connects them as soon as the previous one has finished.)

117. PCO 4 said he was then called to another house block to attend a prisoner who had self-harmed. As he was leaving, PCO 3 entered the hub and PCO 4 said he told him that Ms A wanted a nurse and the other prisoner wanted a Listener. PCO 3 told the Sodexo investigator that he remembered using the cell call system to call the prisoner who had asked for a Listener but did not remember calling Ms A. The cell call system showed PCO 3 called the prisoner who had asked for a Listener and that, at 8.11pm, he called Ms A. The call lasted 15 seconds. At interview PCO 3 said he could not remember PCO 4 handing over any information that evening or speaking to Ms A.
118. The cell call system showed that Ms A made another call at 8.32pm. If a cell call is not answered on the house block hub within a minute, the call goes through to the communications room until it is answered. The records showed that Ms A's call was answered in the communications room at 8.45pm and immediately disconnected.
119. Ms A told the investigator that she had experienced a dragging pain similar to period pain all that day. She had wanted to have a bath but had not been able to. She said she pressed her bell and asked for a nurse and the officer asked her why she needed one. She said she told him that she needed help and a nurse and an ambulance. She rang again a bit later when no nurse came but got no reply. After that she gave up.
120. PCO 5 was the night patrol officer on HB1. PCO 6 was assigned patrol duties across the prison but based herself on HB1 to support PCO 5.
121. CCTV shows PCO 5 completed a roll count soon after coming on duty. At 9.27pm she shone her torch into Ms A's cell. She said she used the torch to make sure the prisoner was in the cell and that she could see movement before moving on. She did not remember where Ms A was in her cell but she said she did not notice anything out of the ordinary.
122. Ms A said that she was on all fours when a torch shone in. By about 11.00pm, she was in constant pain. She had to sit on the toilet and could not get to the cell bell to ring for help. She said she sat on her bed and remembered looking at the TV and thought she then passed out from the pain. A film called *Killer Joe* was on and this was the last thing she remembered. [*Killer Joe* was shown at 1.40am on Channel 4 on 27 September 2019.] When she came round, her baby was there. She managed to bite through the umbilical cord and tied it in a loose knot. She put the placenta on the floor and wrapped the baby in a towel. She said her baby was purple and not breathing. There was blood on the floor and she tried to wipe it up but more came out of her. She put the placenta in the waste bin and got back into bed with her baby.
123. PCO 5 said two prisoners on the same landing as Ms A were subject to ACCT monitoring, and CCTV confirms that she checked these women eight times during the night. She said HB1 was quiet that night and she did not hear anything that concerned her.
124. PCO 6 completed the early morning roll count and CCTV shows she shone her torch into Ms A's cell at 4.19am. She said she did not see or hear anything out of the ordinary during this count.

125. Six other members of staff went to Ms A's landing or the one below it during the night, including three visits by the HB1 nurse to a different prisoner. No one said they heard anything unusual or that caused them concern. The police interviewed the prisoners in the cells either side of Ms A and they said they did not hear anything during the evening or overnight.

Emergency response

126. On the morning of 27 September, PCO 2 began unlocking the prisoners on Ms A's landing for breakfast. He unlocked Ms A's cell at 8.16am and said she was in bed asleep under her duvet. As she was usually one of the last prisoners to get up, he said he did not think this was unusual.
127. At draft report stage, Ms A said she had been listening for the sound of keys and called out to PCO 2 by his first name. He did not respond. PCO 2 left Sodexo Justice Services after we interviewed him and we were not able to re-interview him about this.
128. CCTV showed a prisoner, Ms D, stop outside Ms A's cell and look through her door at 8.21am. Another prisoner, Ms E, did the same less than a minute later. Both prisoners then went downstairs after a brief discussion.
129. Within the same minute, Ms E told PCO 2 that she was concerned about Ms A because she had not come out for breakfast and had shut her door after it was unlocked. At the same time Ms D told Nurse 4, the HB1 nurse, and SPCO 3 that Ms A needed a nurse.
130. PCO 2 returned to Ms A's cell immediately and went in. He said Ms A was in bed with the duvet pulled up to her chin. She looked tearful and he noticed blood on the floor, the duvet, the wall and the sink and toilet. He asked her if she had self-harmed and she said no. He asked her if the blood had come from "down below" and Ms A said it had. She told him she had had her baby and it was dead. She moved the duvet and showed PCO 2 the crown of the baby's head. PCO 2 said Ms A told him she had given birth during the night and had used her cell bell to let an officer know.
131. At 8.24am, PCO 2 radioed a code blue emergency. The communications officer mistakenly thought he was calling to log on to the radio system and did not call the emergency response nurse or an ambulance. Nearly two minutes later, SPCO 3, who had followed PCO 2 to the cell and seen the blood, radioed for the emergency response nurse. SPCO 3 radioed a code red emergency at 8.28am. The communications officer called an ambulance three minutes after that when the duty governor specifically requested one.
132. A number of staff responded to the different radio calls. PCO 2 said he did not say anything about the baby because he had gone into shock, so there was some confusion about the nature of the emergency. Nurse 4 said he assumed Ms A had gone into labour and went to get the emergency bag.
133. PCO 7 said she saw Nurse 4 running with an emergency bag so she followed him. She said Ms A was in bed and did not have any clothes on her top half so she told PCO 2 to leave the cell for decency reasons. Nurse 4 wanted to take Ms A's blood pressure but Ms A would not let him. PCO 7 said as she was trying to persuade Ms A to agree to this, Nurse 1 came in and said, "Is it the baby?"
134. PCO 7 said Nurse 1 asked Ms A a lot of questions but Ms A was quiet. She showed them her baby wrapped in a towel but would not let Nurse 1 take her. PCO 7 managed to persuade Ms A to give her the baby and she laid her on the bed. PCO 7 said the baby was warm and covered in meconium (a baby's first

faeces which is a possible sign of foetal distress if passed during labour). She had a tinge of blue to her lips and looked lifeless. PCO 7 tried to reassure Ms A while the nurses examined the baby.

135. Nurse 2, the emergency response nurse, gave Baby A basic life support under instruction from the ambulance call handler while Nurse 5 spoke to the emergency services on the telephone. Nurse 2 had given neonatal resuscitation only once before. The prison did not have any neonatal or paediatric emergency equipment. The nurses used an adult mask to try to give Baby A oxygen, but it was too big and they were unable to get a proper seal.
136. Paramedics arrived at the prison at 8.41am and took over. They were told that it was not known when the baby was born but that the gestation was 32 weeks. (The basis for this is not clear from Ms A's patient record on SystmOne.) At 9.03am, the paramedics confirmed that Baby A had died. At 10.19am, Ms A and Baby A were taken to hospital by ambulance.
137. The clinical reviewers have looked in detail at the operation of the child death procedures in Ms A's case. Their report contains learning that ASPH and the Surrey safeguarding team will need to address.

Care for Ms A after the birth

138. Before Ms A left for hospital by ambulance, the prison chaplain, baptised Baby A in the cell, and remained with Ms A for support. The prison chaplain also went to the hospital and stayed with Ms A until it was time for her to be escorted back to Bronzefield.
139. On return to Bronzefield that evening, Ms A was admitted to the prison inpatient unit and placed on constant observations under Prison Service suicide and self-harm monitoring procedures (known as ACCT).
140. Ms A told the investigator that she had wanted to stay in her cell to be with her things and be able to vape. She said she was promised she would return to HB1 when she returned from hospital but on the way, she was made to go to the healthcare centre. She said she was very unhappy about this because it felt like she was being punished. She did not have any of her possessions and was kept on the inpatient unit until she was released on bail on 17 October. Ms A was given a memory box containing mementos of Baby A when she left Bronzefield.
141. Ms A was visited by midwives on 2, 8 and 17 October but remained reluctant to engage with them. Prison healthcare developed a multi-disciplinary support plan with input from the senior clinical psychologist and a psychiatrist. No evidence of serious mental illness was identified.

Support for prisoners and staff

142. After Ms A and Baby A were taken to hospital, SPCO 4, from the staff care team, debriefed the staff involved in the emergency response to offer support. The prison provided two support sessions from external counsellors. The prison chaplains, Samaritans and the safer custody team provided support for prisoners affected by the death.

Post-mortem report

143. The pathologist noted that Baby A weighed 6lbs 4 oz and concluded that she was full-term when she was born (that is, between 38 and 40 weeks gestation). The pathologist was not able to conclude whether she was born alive or was stillborn. The pathologist gave the cause of death as ante/intra-partum hypoxia/ischaemia (a lack of oxygen to the brain either before or during birth) due to delayed chorionic villous maturation and a single umbilical artery.
144. Delayed chorionic villous maturation (DVM) is a type of placental disease that restricts oxygen to the baby and can result in stillbirth. DVM can be due to genetic factors, maternal disease (such as gestational diabetes) or drug or alcohol misuse during pregnancy. It is associated with an increased risk of stillbirth or death in the first few weeks of a baby's life.
145. The placenta was small and contained only two vessels (with a single umbilical artery (SUA), instead of the normal two). SUA occurs in approximately 1% of pregnancies and in about 75% of cases the baby is unaffected. However, it can be associated with restricted growth or other problems, and also puts the baby at increased risk of hypoxia (lack of oxygen).

Learning since the birth of Baby A

146. Following the baby's death, Sodexo conducted two internal investigations, one looking at operational issues and one at healthcare issues. As a result of issues identified by this investigation and the two Sodexo investigations, Bronzefield has made a number of changes to policy and practice, including:
 - Hourly checks for all pregnant women in their third trimester.
 - NHS pregnancy advice line added to prison telephone system.
 - A fortnightly pregnancy review board attended by midwives, healthcare and operational staff provides a coordinated oversight of pregnant prisoners.
 - A review of the complex case ledger and extended observations.
 - Invitation of midwives to all multi-disciplinary reviews for pregnant women.
 - Training for clinical staff in neo-natal resuscitation and the purchase of suitable emergency equipment.
 - Further guidance to operational staff on what is expected:
 - When a prisoner asks for a nurse.
 - When responding to a cell bell.
 - When carrying out a welfare check.
 - On receipt of child protection information.
 - On receipt of a code red or code blue medical emergency radio call.

Findings

Overall conclusion

147. Ms A was a vulnerable young woman with a complex history. Her traumatic childhood resulted in, among other things, a lack of trust in people in authority. Understandably, she was a challenging person to care for, but her history meant that it was even more important for those with a duty of care to get their approach right and for that care to be properly trauma-informed. With the benefit of hindsight, although several individuals tried their best to engage with Ms A, we found that the approach to managing and supporting her was neither co-ordinated nor trauma-informed.
148. Ms A refused antenatal care prior to her arrival at Bronzefield. As a prisoner there was conceivably greater opportunity for clinical oversight of her care, but this did not happen. There was no clear pathway of care at Bronzefield for pregnant women who are ineligible or unsuccessful for placement in the MBU, and no system of healthcare leadership that takes account of the needs of pregnant women, particularly of those women who do not embrace their pregnancy.
149. There was poor communication between the various parties responsible for Ms A's care, meaning that no one had a complete picture, and confusion and poor communication about her estimated date of delivery meant that prison staff did not know the birth might be imminent. In the days leading up to Baby A's birth there were several missed opportunities to increase observations on Ms A that might have led to her labour being discovered. The response to Ms A's calls for a nurse that evening was inadequate.
150. The clinical reviewers have concluded that, overall, the healthcare offered to Ms A in Bronzefield was not equivalent to that which she could have expected to receive in the community. In addition, we found that maternity provision at Bronzefield was insufficiently resourced and too narrow in scope to meet the needs of pregnant women held there.
151. We discuss individual aspects of the care offered to Ms A in more detail below and make recommendations throughout the text. Our recommendations seek to support the changes already implemented by Bronzefield (listed at paragraph 146), promote wider learning across the women's prison estate and ensure that all the learning from this investigation has been captured and can be evidenced in effective change.
152. We also discuss learning from previous births at Bronzefield and national learning from the death of a woman in a different prison in 2015.

Care of Ms A at Bronzefield prior to the birth of her baby

Poor information sharing and the lack of a co-ordinated approach

153. No one responsible for Ms A's care had a full history of her pregnancy from the first test on 28 February that indicated she was pregnant. Multiple record systems were involved including BadgerNet, SystmOne, NOMIS (the HMPPS

record system), the MBU drive and social services records. None of these systems spoke to each other, none of the separate records contained sufficient information on their own for proper oversight of Ms A, and no single person involved had access to them all.

154. Some information, such as the minutes of the child and family assessment on 17 July and the child protection case conference on 23 July, was simply not shared between different departments in Bronzefield. Some, like Ms A's community GP records, were not requested as they should have been. All this precluded anyone taking an overview and making decisions based on all the available information.
155. The midwives were only able to access SystmOne when they were in Bronzefield. When they wanted to raise concerns about Ms A more immediately, as they did on 6 and 25 September, they had to use email. This produced a response but relied on someone else adding the information to SystmOne for wider sharing. This was done on 6 September, but not on 25 September. The midwives told us that, if they referred a woman to the mental health team or substance misuse services, they did not hear back from healthcare and had to find out whether this had happened from the woman concerned.
156. Although the midwives used SystmOne to record interactions with pregnant women, they generally communicated with the MBU team and not with prison healthcare. As a result, there was very little information on Ms A's patient record on SystmOne about her pregnancy. For example, on 20 August, the safeguarding support midwife emailed Ms B, the MBU administrator, and said she believed that Baby A was due "Oct/Nov." No information about Ms A's estimated due date, the child protection information or the safeguarding support midwife's risk assessment and care plan for Ms A appeared on SystmOne. According to Sodexo, prison healthcare staff were not aware of the child protection plan until October 2019 when they attended a safeguarding review meeting after the baby's death.
157. When the family support worker raised concerns on 20 September, these too were shared with the MBU team and not with healthcare staff. At the time the main responsibility for all pregnant women at Bronzefield and the safeguarding needs of their unborn children fell, in practice, to the SPCO in the MBU, regardless of whether the woman was likely to get a place on the MBU or not (as in Ms A's case). The MBU SPCO is extremely dedicated to his role and obviously cares a great deal, but he is not a clinician or a midwife and does not have access to SystmOne or BadgerNet. He did not, therefore, have the information necessary for fully-informed decision-making.
158. The midwives did not attempt to involve prison healthcare staff in more basic nursing tasks. For example, when Ms A refused to have an anti-D immunoglobulin injection and to give blood because she was frightened of needles, both of these tasks could have been handled by prison nurses who were in the prison. The single nurse who appeared able to form a relationship with Ms A was encouraged to persuade her to have a scan, but this was an informal arrangement made at a chance encounter and not part of a coordinated plan.

159. Even if all the available information had been shared, we identified a disassociation from the day to day care of pregnant women by prison healthcare staff. The clinical lead nurse with responsibility for the MBU (and by extension pregnant women), was not sufficiently engaged with this part of her role and the expectations of it had not been set out. The role played by healthcare staff consisted largely of telling the midwife when Ms A refused a scan. They did not take responsibility for trying to find out why Ms A refused to engage and showed little professional curiosity.
160. Maternity care has become increasingly midwife-centric in the community and this was reflected in Bronzefield. However, a midwife-centric clinic-based model is not appropriate in a custodial setting where the midwives visit only twice a week, the obstetrician holds only eight clinics a year and the prisoners do not have direct access to them. Women in the community are able to contact their midwife direct.
161. In the community, the GP is also involved in maternity care, but in Bronzefield the GP's sole involvement with pregnant prisoners was to refer them to the midwife and to prescribe. The clinical reviewers pointed out that, unlike prison nurses, GPs have experience of working in obstetrics and could potentially play an effective role in the day to day care of pregnant prisoners. At interview there was confusion about whether the GPs automatically prescribed supplements to pregnant prisoners on reception. The GP we interviewed said he did not think it was his responsibility to prescribe items like vitamin D for pregnant prisoners unless the midwives requested it.

Lack of trauma-informed care

162. The two midwives involved in Ms A's care were senior and experienced clinicians. They held specialist roles as the support midwives for safeguarding and vulnerable women at ASPH.
163. The minutes of the child protection case conference on 23 July were sent to the midwives and to the prison's Offender Management Unit. The minutes contained valuable information about Ms A's denial of pregnancy, traumatic past and fear of having her child removed. They noted her evident "fear, despair, worry and stress" when discussing her baby. (These minutes were not shared more widely at Bronzefield.)
164. We consider that the content of these minutes and the fact that there was a child protection plan in place should have prompted the safeguarding midwives to take a different approach to engaging Ms A with her pregnancy. The clinical reviewers considered that Ms A's disassociation from her pregnancy should have led to extensive discussion with obstetric and psychiatric colleagues about how to engage with her. Instead, Ms A was repeatedly asked to attend scans and participate in groups even when it became obvious that this approach was not going to work.
165. We find the inflexible, unimaginative approach to Ms A's care concerning, especially given that, as safeguarding midwives for vulnerable women, trauma-informed care should be at the heart of their role. A significant number of interviewees told us that Ms A's lack of engagement with midwifery was

unprecedented at Bronzefield. However, in any service, women will be seen who are fearful and ambivalent about their pregnancies. There was no plan for managing a mother who actively avoided contact with midwifery services, no investigation of what lay behind her disassociation from her pregnancy, and no Plan B when Ms A refused to accept the usual procedures which focussed on her baby rather than on her.

166. We also consider that information about social services' concerns for Baby A and background information about Ms A was available to the prison and should have been shared with prison healthcare staff. However, given the healthcare staff's lack of involvement with pregnant prisoners and the fact that the prison had no perinatal pathway or pathway for high risk pregnancies, we doubt this would have made much difference. On 19 August, the safeguarding support midwife wrote on SystmOne that Ms A's was a high risk pregnancy but there is no evidence that this made any practical difference to the care she received from healthcare.
167. There is a commitment at senior prison manager level to delivering trauma-informed care at Bronzefield but we saw little practical evidence of this in the healthcare for Ms A. Ms A appeared to have been regarded as difficult and having a 'bad attitude' rather than as a vulnerable 18 year old, frightened that her baby would be taken away.

Complex case ledger and extended observations

168. The lack of a co-ordinated and trauma-informed approach is also evident in Ms A's management on the complex case ledger. This is a register of patients with complex needs recorded in SystmOne. Extended observations are, similarly, for prisoners who require extra monitoring. They are normally used for prisoners with severe withdrawal symptoms in the early stage of substance misuse detoxification. In September 2019, neither process was set out in an operating protocol and there was no standardised expectation of what staff were required to do.
169. The understanding of most clinical staff appeared to have been that prisoners on the complex case ledger would be seen daily by a nurse, weekly by a GP and their case would be discussed weekly in a multi-disciplinary team meeting (although any decisions taken were not recorded on the prisoner's individual medical record). The general understanding of extended observations was that the prisoner would be seen by a nurse each morning, afternoon and evening and a minimum of twice overnight. Extended observations do not appear to be part of the planned care for an individual as they are not captured in the prisoner's patient record on SystmOne and they are not part of an overall care plan.
170. Ms A was placed on the complex case ledger on 6 September and on extended observations on 26 September. She did not see a nurse every day and she did not see a GP every week. There was no guidance on what type or frequency of observations were appropriate for a vulnerable pregnant mother with a high-risk pregnancy nor, beyond a very basic emergency outline, what escalation was expected. The extended observations did not happen due to a failure to communicate the decision to HB1 nurses.

171. However, we consider that a more fundamental issue is that neither the complex case ledger nor extended observations are processes designed to monitor, review or care for pregnant women, least of all a young woman with a high-risk pregnancy who has refused all maternity care. None of the daily checks involved feeling the baby or estimating gestation or checking for signs of labour. Ms A's assertions that she "knew what to do" if she needed help were not tested or explored despite her age and lack of engagement with the midwives.
172. Even when Ms A's baseline observations were outside the normal range, as they were on two occasions, no action was taken. On 18 and 19 September, the free text entry appeared to have been copied and pasted from one day to the next. There were no complex case ledger checks on 20, 21 and 22 September. Ms A was seen by a nurse at the medication hatch, but this did not even involve her baseline observations being taken, much less count as a meaningful interaction.

Ms A's proposed move to the inpatient unit

173. Another example of the lack of coordinated trauma-informed approach was the plan to move Ms A to the prison's inpatient unit. This is not an appropriate environment for any pregnant woman, especially one in the later stages of pregnancy. The beds are allocated to very sick prisoners or very mentally unwell prisoners waiting for transfer to secure mental hospitals. We understand that there is no suitable unit at Bronzefield for monitoring women with high risk pregnancies and that the plan to move Ms A to the inpatient unit was seen as a last resort by the operational manager in charge, but a 'last resort' implies that other strategies have been explored, and we have seen no evidence of this.
174. We consider that SPCO 1's decision not to move Ms A from HB1 against her will was the correct one. However, when Ms A was not moved, there was no clear plan for what to do instead and the decision was not well communicated. The clinical nurse manager appeared to have made a unilateral decision at a late stage on 26 September that Ms A should be moved to the inpatient unit on 27 September. However, the clinical nurse manager was not at the meeting on 25 September that discussed concerns about Ms A. The minutes were not uploaded to SystmOne until 28 September and the decision that Ms A should remain on HB1 was not recorded on SystmOne.

Ms A's estimated delivery date (EDD)

175. The first clinical information indicating that Ms A was pregnant was her positive pregnancy test in police custody on 28 February. At the same time, she said that her last period was in December 2018. Using this information, the clinical reviewers used a gestation calculator (pregnancy wheel) and calculated Ms A's estimated delivery date range between *6 September and 6 October*, assuming a pregnancy of 40 weeks.
176. No one responsible for Ms A's care calculated her estimated delivery date using this information. A Camden social services strategy review meeting on 25 March referred to Ms A's statement that her last period was in December. Despite this, the meeting recorded her estimated delivery date as *1 August 2019*. This appears to be in line with a community nurse's visual estimate made on 6 March.

177. We consider that more consideration should have been given to Ms A's statement on 28 February at this point, especially as it was made alongside a positive pregnancy test. It was the first available information about her pregnancy and should have been used as a baseline estimate, unless and until disproven by a foetal dating scan or other clinical information.
178. Although Ms A subsequently denied being pregnant and the original child protection case was closed, the clinical information obtained on 28 February was not revisited when it became obvious that Ms A was pregnant and her case was reopened. This was a missed opportunity to accurately estimate Ms A's delivery date.
179. Ms A's estimated delivery date was also not recalculated using the February information at the child protection conference on 23 July, when it became apparent that the delivery date of 1 August was wrong. Instead an estimate of a 20-week pregnancy, made at UCLH on 4 July, was used to calculate a due date of *21 November*. The minutes noted this estimate was based on 'stomach size' and that the due date was unclear.
180. On 16 August, the UCLH midwife emailed the safeguarding support midwife and said she thought Ms A "may be expecting in *November*". This rather vague information, and three entries on SystmOne reporting that Ms A said she was six or seven months pregnant when she arrived at Bronzefield was all that the safeguarding support midwife had to go on before she met Ms A on 19 August. (She subsequently received the minutes of the child protection conference on 23 July, although we do not know exactly when because the minutes were not uploaded to BadgerNet until October.)
181. The safeguarding support midwife's measurement of a symphysis fundal height (SFH) of 32cm on 19 August represented the most objective clinical measure from which to calculate Ms A's due date. The SFH suggested a delivery date range of *24 September to 14 October*, assuming a 40-week pregnancy. At the same consultation, Ms A told her that she was 27-28 weeks pregnant.
182. At interview the safeguarding support midwife acknowledged that the 32cm measurement was the most reliable clinical information available but said she did not calculate a due date from it because she was hopeful that Ms A would agree to a scan. At the same time, she acknowledged that a scan at such an advanced stage of pregnancy would not have provided best evidence of a clear due date. A revised estimate based on a gestational age of 32 weeks would have correctly forecast the delivery date range. This was the best opportunity to obtain clarity about when Baby A was due - and it was not taken.
183. The clinical reviewers also pointed out that the difference in the estimated gestation of 27-28 weeks reported to the safeguarding support midwife by Ms A and the fundal height measurement of 32cm was sufficiently different to have required further consideration. It indicated an unusually large baby for the reported gestation, especially because the safeguarding support midwife knew that Ms A drank heavily and smoked during pregnancy and these are both factors known to reduce the growth of a baby.

184. We note that 32 weeks gestation on 19 August corresponded almost exactly with the only other clinical evidence from 28 February. If the safeguarding support midwife had been aware of that it might have caused her to think differently about calculating the due date from the fundal height. This is another illustration of the importance of continuity in care and communication between agencies.
185. On 20 August, the safeguarding support midwife emailed Ms B that she thought Ms A was between 27-32 weeks pregnant. On 9 September, three weeks later, the safeguarding support midwife told the midwife from UCLH, that her best estimate was that Ms A was now 30-35 weeks pregnant. On SystmOne the safeguarding support midwife recorded that the gestation was unknown, and it was impossible to calculate a due date.
186. On 26 September, some two and a half weeks after estimating 30-35 weeks to UCLH, the safeguarding support midwife emailed SPCO 1, the family support worker and healthcare and said her estimate was 31-35 weeks. It is not clear why she did not add the intervening two and a half weeks. We consider that the sensible course would have been to calculate a due date based on the only clinical information available, however imperfect, and plan for the earliest possible date.
187. We consider that the midwives and consultant obstetrician concentrated too much on information they did not have, i.e. a foetal dating scan, and not enough on information they did have. The midwives and the clinical and custodial staff all appeared to accept, wrongly, that the lack of a scan meant the delivery date could not be calculated.

Investigation of gestational diabetes

188. The clinical reviewers also concluded that Ms A should have received a glucose tolerance test after her urine showed glucose on 19 August. This was indicated because her ethnic heritage and weight increased her chances of gestational diabetes. (The post-mortem showed a condition in the baby that can be caused by gestational diabetes.) At the draft report stage the safeguarding support midwife said she offered Ms A a glucose tolerance test but Ms A refused. This offer was not recorded in the records as it should have been.

Assessment of Ms A's risk to herself and her baby

189. Prison Service Instruction (PSI) 64/2011 contains guidance on the management of prisoners at risk of harm. It is a mandatory action that all staff who receive information which indicates a change in the risk a prisoner poses to themselves or others should communicate their concerns to operational managers and consider ACCT monitoring procedures.
190. Ms A told Nurse 3 on 25 September that she would kill herself or someone else if her baby was taken away from her. Nurse 3 said he did not consider ACCT monitoring, as he should have done, because he thought Ms A was being watched already. It seems likely that Nurse 3 confused ACCT monitoring with Ms A's placement on the clinical complex case ledger. If he had thought Ms A was already being monitored under an ACCT, he should have recorded her comments about killing herself in her ACCT documentation.

191. PCO 2, who was made aware of Ms A's threat to kill herself, said that he did consider beginning ACCT monitoring but that he decided not to because he did not want to stress Ms A and he thought, based on her size, that Ms A was about seven months pregnant.
192. We consider that Nurse 3 and PCO 2 should have opened an ACCT in the light of Ms A's comments. Even without confusion over what monitoring Ms A was subject to, neither of them had all the available evidence on which to assess Ms A's risk to herself and her baby. The poor definition and inconsistent application of the complex case ledger process, combined with a lack of awareness amongst healthcare and wing staff that Ms A's pregnancy was high risk and the delivery date uncertain, once again undermined effective decision-making about her care. If she had been monitored under ACCT, it is likely that she would have been subject to regular checks and this would have led to the earlier discovery that she was in labour.
193. We recommend:
- The Director and Head of Healthcare at Bronzefield should remind all staff of their responsibility to open ACCT procedures if they consider that a prisoner may pose a risk to herself.**
- The Head of Healthcare at Bronzefield should share this report with Nurse 3 and discuss the Ombudsman's findings with him.**

The events of 26/27 September

194. The poor communication that we have already discussed meant that concerns about the uncertainty of Ms A's delivery date and that she might give birth alone, do not appear to have filtered down to staff on HB1 responsible for Ms A's day to day care. Most prison staff we spoke to said they thought Ms A was not due to give birth until November. This included PCO 2 who was on duty on 26 and 27 September. When Ms A asked for a nurse on 26 September, neither of the officers who spoke to her appear to have connected her need for a nurse with the fact she was pregnant.

Cell bell calls

195. Neither PCO 4 nor PCO 3 responded appropriately to Ms A's request for a nurse on 26 September and the officer in the communications room did not answer Ms A's second bell at all. We are aware that PCO 3 had suffered some trauma that impaired his memory some years before. At interview we became concerned for his welfare. He expressed anxiety about his employment in duties with direct contact with prisoners and we understand that he has since moved to different duties. We were unable to interview PCO 4 as he was absent from work for a long period.
196. Whatever the reason, the response to Ms A's request for a nurse was inadequate and the failure by the communications officer to answer her second call was unacceptable. We note the last HMIP report identified concerns that cell call bells were not being answered promptly and in some cases were being cancelled before the prisoner could speak or request assistance. Bronzefield accepted HMIP's recommendations to address this issue and introduced a number of new

measures to ensure compliance, including implementing a quality assurance process, issuing staff information notices, refresher training and monthly assurance checks. These measures were due to be put in place by July 2019.

197. This is a very serious matter. A proper response to Ms A's request for a nurse may have resulted in a less traumatic outcome for Ms A. It is extremely concerning that this has been a long-standing issue at Bronzefield. HMIP's report from 2018 said presciently that ending calls before the prisoner could request assistance "could have posed a risk to prisoners in crisis". Unfortunately, this was found to be true for Ms A.
198. Following the death of Baby A, all three members of staff involved with Ms A's cell calls were moved to duties that did not involve direct contact with prisoners, pending consideration of a disciplinary investigation. The prison has since provided further guidance to all staff on the expectations for responding to cell bells and requests for a nurse or medical assistance.
199. We recommend:

The Director of Bronzefield should commission a local investigation into the failure to respond to Ms A's request for a nurse and to answer her cell bell on the night of 26 September and consider whether disciplinary action is appropriate.

Extended observations

200. As we have said, Ms A was placed on extended observations on 26 September. However, the extended observations did not happen because no one told the HB1 nurses. The absence of the extended observation night checks on 26/27 September was another missed opportunity to discover that Ms A was in labour.

Emergency response

201. PSI 03/2013 requires governors to have a two-code medical emergency response system based on the instruction. As is usual, Bronzefield use code blue to indicate an emergency when a prisoner is unconscious or having breathing difficulties, and code red when a prisoner is bleeding. Calling an emergency code should automatically trigger nurses to attend and the control room to call an ambulance immediately.
202. The control room officer did not recognise that PCO 2 had radioed a code blue emergency at 8.24am on 27 September and took no action. SPCO 3 radioed for the emergency response nurse a minute later, followed by a code red emergency at 8.28am. The control room officer did not call an ambulance until 8.31am after the duty governor specifically asked for one. Although this did not affect the outcome for Baby A, prompt attendance by emergency services might prove crucial in other cases. Bronzefield have already provided refresher training on how to respond to an emergency code in the light of events that day. We therefore make no recommendation.
203. Bronzefield had no paediatric or neonatal emergency equipment and none of the staff were trained in neonatal resuscitation. Baby A was given oxygen via an adult mask which would have had no practical effect. The clinical reviewers also

pointed out that there was no emergency response plan in the event of an unexpected or very sudden labour that captured the advice of the Resuscitation Council. This should have been in place as an adjunct to a maternity pathway.

204. A further concern is that there was no checklist prompting clinical staff to ensure that everything needed by the hospital in order to follow the required child death investigations was taken to hospital with Ms A. This included locating the placenta.
205. In response to the death of Baby A, Bronzefield have trained all response nurses, clinical leads and clinical managers in neonatal resuscitation. Face masks and defibrillator wires and pads for use in resuscitating new-born babies have been purchased and are kept with the defibrillator on the mother and baby unit.
206. We recommend:

The SJS Healthcare Manager should establish a clear process for emergency responses to births at Bronzefield to ensure that immediate practical basic assistance can be provided.

The Director of Bronzefield, the SJS Healthcare Manager and the Director of Midwifery at ASPH should each commission an independently facilitated session for their staff to enable a reflective discussion of this case.

The Sodexo Healthcare Manager should obtain external expert advice about:

- **the level of training and expertise that should be available in the prison in relation to neonatal and child resuscitation; and**
- **the resuscitation equipment that should be provided.**

Care for Ms A after the death of Baby A

207. When she returned from hospital on 27 September, Ms A was placed in the prison's inpatient unit against her wishes. We consider that this decision was inappropriate given that Ms A was neither seriously physically or mentally ill. She had made friends on HB1 and was left without their support and the majority of her possessions.
208. However, we commend the multi-disciplinary support plan developed by healthcare and psychology which was clear and identified issues and approaches to best support Ms A when she returned from hospital. It is a shame that this sort of support was not considered until after Baby A died.

Maternity services at Bronzefield

An outdated and inadequate service

209. Neither we nor Sodexo nor ASPH were able to find a current contract or service level agreement setting out the resources, performance expectations, governance or contract management of the maternity services at Bronzefield. The original provision of services appears to have been on an informal basis or verbal agreement. Crucially the services provided have not been re-profiled

since the prison opened in 2004, even though the number of pregnant women there has more than doubled since the closure of HMP Holloway in 2016. As a result, the obstetric and midwifery resource allocated to Bronzefield is not commensurate with the size or complexity of the caseload.

210. A detailed explanation of the history of the contract and the current NHS England and Improvement (NHS E/I) expectations for governance and oversight is contained in the clinical review. We have concluded that ASPH is effectively commissioned to provide a general midwifery service rather than to deliver a specific service. The service does not appear to comply fully with the principles of NICE Guidance CG 110 “Pregnancy and Complex Social Factors”.
211. Discussions with the prison and the ASPH team during the investigation did not suggest that a business case had been put to the CCG for additional resources, but rather that staff have simply tried to do their best to meet demand. While this is commendable, and we appreciate that the midwives in particular go above and beyond to deliver a service to Bronzefield, the result is that a very outmoded model of provision that has not been adapted to meet the needs of pregnant prisoners has continued.
212. One of the likely reasons for this is that none of the healthcare staff or healthcare senior management employed in Bronzefield or Sodexo have current or past registration as midwives. As a result, they have not had a good understanding of what a specialist midwifery service might look like and what is needed in a custodial environment. A further concern is that, as there is no specification for the midwife role in the prison, it would not be possible for anyone else to step in if the current midwives were absent from work for a significant period for any reason.
213. We recommend:

The Director of Bronzefield, the SJS Healthcare Manager, the Head of Healthcare at Bronzefield, the Health and Justice Commissioning Lead for the NHS Surrey Heartlands Clinical Commissioning Group, and the Director of Midwifery at Ashford and St Peter’s Hospitals NHS Foundation Trust (ASPH) should:

- **work together to urgently re-profile and update the maternity service provision at Bronzefield to reflect the increased demand since the closure of HMP Holloway; and**
- **ensure that the maternity service is sufficiently resourced to provide:**
 - **an appropriately qualified midwifery lead to oversee all aspects of perinatal care;**
 - **the development of a maternity pathway for prisoners that includes a process for those women who decline to engage with services and access to psychological and psychiatric services for support;**

- a forum for everyone that provides clinical care to pregnant women to discuss individual cases and that relevant discussion is recorded in SystmOne;
- remote access for the ASPH midwives to SystmOne;
- training in trauma-informed care, recognising early signs of labour and neonatal and child resuscitation procedures;
- appropriate emergency resuscitation equipment for children and neonates; and
- guidance on how to respond to births in prison.

Lack of effective oversight of the midwifery team

214. This problem of an inadequate midwifery service has been compounded by a lack of effective oversight for the midwifery team. We have been unable to identify exactly how the ASPH board exercises oversight of this aspect of its clinical service. We found that the level of support and oversight is not sufficient to meet the level of risk involved. There are a number of recommendations about this issue in Annex 3 that need to be addressed as a matter of urgency.
215. There is no effective oversight from the prison either. The Ministry of Justice Controller is not supported by a clinical advisory team and much of the contractual oversight is focussed on numerical data. There is little collection and analysis of qualitative information. The current Controller relies on NHS E/I to provide oversight and advice, but this is not formally part of the NHS E/I commissioner's role. Like too many important roles it relies on goodwill and individuals prepared to go beyond what they are expected to do. Moreover, the Controller needs to satisfy himself independently that the commissioned service is adequate for the level of need at Bronzefield.
216. We recommend:
- The Head of Custodial Contracts in HM Prison and Probation Service (HMPPS) should write personally to the Ombudsman setting out how they will ensure that the MOJ Controller is able to exercise effective contractual oversight of healthcare services at Bronzefield.**

Equivalence of healthcare provided to Ms A

217. The clinical reviewers used the principle underlying equivalence defined by the National Prison Healthcare Board (which is based on a system-design level rather than a consideration of clinical decisions in individual cases). By this definition they concluded that the healthcare provided to Ms A was not equivalent to the wider community because the system design for Bronzefield's maternity service is outmoded.
218. They concluded:
- “In considering the equivalence of care at an individual case level, there were errors and opportunities were missed to develop a clear and coordinated plan. The plan should have been based on “worst case

scenario” which reflected the strong probability that Ms A’s estimated date of delivery was incorrect.”

Learning from previous incidents

Local learning

219. Our investigation examined previous unexpected births in Bronzefield and the prison’s response. A birth in 2017 shared some significant similarities with Baby A. We found evidence of some learning as a result, but it was not clear that this had led to effective changes in practice.
220. Following the birth in 2017, ASPH refused a request from the prison for maternity packs on the grounds the staff were not trained to use them. Such packs would have been of benefit both at another birth in March 2019 and in Baby A’s case.
221. We note that the publicly available ASPH Board reports said that learning from the birth would result in “strengthened surveillance of foetal growth, focussing on measuring uterine growth via the symphysial fundal height measure”, and that a maternity pathway was being developed for the prison. This strengthened surveillance was not apparent in Ms A’s case.
222. We consider that the similarities with Ms A and the previous unexpected birth in 2017 should have led to a much clearer maternity pathway with specific advice for the prison about unexpected births. Plans for a maternity pathway were referred to as being “under development” for a significant period of time. We asked to see these plans, but none were provided. We also requested specific incident reporting from ASPH for the previous births, but we did not receive this either. We have seen no evidence that these incidents were properly scrutinised. We are concerned that investigations have not been multi-professional or done with the prison but consisted of a desk review to check adherence to guidelines.
223. The quarterly Maternity Services Liaison Committee (MSLC) was created in early 2018 in an attempt to bring together all the stakeholders and improve the quality of care for pregnant prisoners at Bronzefield. Representatives from the prison, NHS E/I and the midwifery team at ASPH all attended, alongside support groups and charities working with pregnant women in prison.
224. An examination of the minutes of the MSLC, showed the following issues had been identified:
 - A need for improvement in information sharing.
 - A need for specific GP/nurse appointments for pregnant women.
 - There was an opportunity to learn from the perinatal pathway at HMP Low Newton.
 - There was an opportunity to case study high-risk pregnancies and look for learning.
 - There was a need for a group to support mothers being separated from their babies with input from mental health and the prison psychologist.

- There was an opportunity to visit HMP Foston Hall and learn from their post-natal/perinatal mental health pathway.
 - Supplements and vitamins for pregnant women were not routinely given by healthcare staff despite NICE guidance that they should be prescribed at reception.
 - A need for officers escorting pregnant women to hospital to have training in signs of labour and attending women with newborn babies.
225. The MSLC was a good initiative and a useful forum but we saw little evidence that the issues it identified drove quality improvement. Its wide membership meant it should not have been a place for the clinical discussion of individual cases that occurred. It appears that this aspect of its role probably arose because there was no secure clinical forum in the prison that specifically discussed pregnant prisoners.

National learning

226. In many ways the situation for pregnant women in Bronzefield was symptomatic of a national absence of policies and pathways for pregnant women in custody. At the outset of our investigation it was apparent that the National Women's Team in HMPPS were not sufficiently sighted on the number of pregnant women in prison and did not hold statistics on them.
227. The HMPPS guidance on mother and baby units was out of date and subject to a review. The old guidance focussed on application to, selection for and operational management of women in MBUs. Pregnant women who were unsuccessful or ineligible for MBUs did not figure at all. We are concerned that, apart from giving advice on where pregnant women who do not fit MBU criteria should be housed in prison, the revised guidance, issued in July 2020, is similarly silent on the matter. It is also silent on cases where child protection measures are in place and the baby's removal from the mother is planned.
228. The need for a multi-disciplinary trauma-informed approach to pregnant prisoners is not new learning for the Prison Service. In 2015, in an investigation into the death of a new mother at Low Newton the PPO made the following recommendations:
- *The Governor and the Head of Healthcare should ensure that every pregnant woman with complex needs has:*
 - *A named care coordinator.*
 - *A multidisciplinary meeting at an early stage to identify risk factors and plan for the birth and postnatal period.*
 - *A multidisciplinary care plan for mental, physical and social care which allocates actions to named individuals.*
 - *An additional separation plan to support the woman if her baby is likely to be taken into care.*
 - *The Governor and the Head of Healthcare should ensure that Low Newton's local safer custody policy reflects the particular needs of women,*

including the risks associated with pregnancy, children being taken into care and the postnatal period.

229. The Low Newton death resulted in the employment of a full-time midwife at that prison with a remit to develop a perinatal pathway mapped against the mental health pathway. This template became the basis for a national perinatal pathway involving collaboratively commissioned midwifery services and a specialist midwife role in mental health and substance misuse. Bespoke pathways for every women's prison were due to be rolled out in April 2020 but this has been delayed by the COVID-19 pandemic.
230. While this pathway is very welcome, we note that the bespoke perinatal pathway proposed for Bronzefield concentrates on women with serious mental illness. It would not therefore have applied to Ms A. It also reinforces the midwife's position at the centre of care for pregnant prisoners.
231. The real dearth of care highlighted by this investigation is for women who, for whatever reason, are unable to engage with their pregnancies and those who will be separated from their babies after birth. As the focus of midwifery is primarily on the baby, it is not appropriate that they fill this void alone.
232. We recommend:

The Director of Health and Justice for NHS England should consider the findings and recommendations in this report and ensure that the learning is applied across the women's estate. This should include recognition that:

- **the clinic based community model of midwifery care is not appropriate to a custodial setting; and**
- **all pregnancies in prison are high risk.**

Incidental findings

233. The investigation identified some significant incidental findings some of which are summarised below, and which are discussed in greater depth in the clinical review. We provide a summary of the main points below and a list of the relevant recommendations are provided at Annex 3. It is important that these are taken forward. We therefore recommend:

The Director of Bronzefield, the SJS Healthcare Manager, the Head of Healthcare at Bronzefield, the Health and Justice Commissioning Lead for the NHS Surrey Heartlands Clinical Commissioning Group, and the Director of Midwifery at ASPH should each address the further recommendations from the clinical review (listed at Annex 3) and should each provide an action plan setting out their response.

Management of child death procedures

- 234. Hospital emergency departments are practiced in responding to the arrival of a child that has recently died in the community. However, contrary to the statutory guidance on child death procedures, Baby A was taken to the labour ward rather than the emergency department at ASPH. This resulted in a significant delay in taking post-death samples (Kennedy samples).
- 235. Kennedy samples are particularly important in an unexpected and unexplained death. They allow the identification of bacterial and viral infection (important in terms of containing risks to public health) and provide a back-up for samples taken at the post-mortem. It becomes increasingly difficult to take reliable samples with the passage of time after death. Baby A arrived at ASPH at 10.52am but an attempt to take the samples was not made until after 4.00pm.
- 236. The placenta was recovered from Ms A's prison cell at 12.55pm but did not arrive at ASPH until 4.30pm. It was placed inside several sealed evidence bags and the midwife who examined it did so through at least one bag. Examination of the placenta is mandatory in all births and provides an opportunity to identify issues with the baby at an early stage. In this case, the midwife identified, wrongly, that there were three cord vessels in Baby A's placenta when in fact the post-mortem showed only two. If this had been known at the time it might have informed the immediate police investigation.
- 237. Police and Coroner involvement immediately after Baby A's death, and a lack of understanding by the prison of the role of the local Child Death Review Team, meant that Ms A did not receive the routine bereavement and practical support that would normally be provided to a bereaved mother by the child death review nurse for Surrey.
- 238. Bronzefield and the Surrey Child Death Review Team now have strong links and a prison-specific flowchart has been designed to ensure that in future a bereaved mother will receive immediate emotional and practical support following the loss of her baby. A local protocol is now in place providing for an informal review by the Surrey Child Death Review Team of any baby death in the prison.

Healthcare for babies and children in the mother and baby unit

- 239. The babies and children in the MBU are registered with local GP practices. As such, and because they are not prisoners, they are entitled to be seen in the usual way by the health visitor. At present the prison pays for this service, however the clinical reviewers concluded that as the children are the patients of community GPs it is unclear why an additional payment is required. Of greater concern, is that a fundamental requirement of child health is being breached because babies and children are seen by clinicians who have no knowledge of the mother's health and well-being as they are not registered at the same practice.

Child safeguarding

- 240. The investigation identified that safeguarding training in Bronzefield was inconsistent and there was a lack of the child-focussed safeguarding required by the Children Act 2004. The offender supervisor is expected to write reports

considering risk for the MBU boards but has not received safeguarding training and we were told that they often received important information only 15 minutes before the boards. In September 2019, the prison had stopped attending Surrey children's partnership board meetings.

Independent investigation by the Prisons and Probation Ombudsman into the death of a baby at HMP Bronzefield

Terms of Reference

Purpose

The Secretary of State for Justice has commissioned the Prisons and Probation Ombudsman (PPO)¹ to:

- investigate and report on the decisions, actions and circumstances surrounding the death of a baby at HMP Bronzefield overnight between 26 and 27 September 2019;
- review the clinical care provided to the baby's Mother in conjunction with NHS England & NHS Improvement (NHS E/I) and the Surrey Child Death Partnership Team (CDPT);
- ensure 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 made clear;
- provide explanations and insight for the baby's Mother
- help fulfil the investigative obligation arising under Article 2 of the European Convention on Human Rights ('the right to life'); and
- make any appropriate recommendations.

Scope

In particular, the PPO will set out the reasons for remanding the baby's Mother to prison and investigate:

- information sharing processes between the court and prison
- the operational management of the baby's Mother by HMP Bronzefield;
- the clinical care provided to the baby's Mother while she was at HMP Bronzefield, including:
 - the baby's Mother's perspective;
 - whether the clinical care was appropriate and sufficient for the baby's Mother's needs and equivalent to that provided in the community; and
 - whether the clinical care complied with relevant prison and health policies and clinical guidelines for pregnant women;
- the levels of integration and information sharing between the differently commissioned and provided services working with, or that should have been working with, the baby's Mother's care; and
- whether any changes in operational methods, policy, practice or management arrangements of the services involved would help prevent similar deaths in future.

¹ The PPO is wholly independent of HM Prison and Probation Service in England and Wales. The PPO is appointed through an open competition by the Secretary of State for Justice. The Ombudsman's office is operationally independent of, though it is sponsored by, the Ministry of Justice. The Ombudsman reports to the Secretary of State. The PPO's Terms of Reference are at www.ppo.gov.uk

Method

- The PPO may defer all or part of the investigation when the police are conducting a criminal investigation in parallel.
- The PPO will work closely with the Surrey Child Death Partnership Team (CDPT) and a clinical reviewer commissioned by NHS E/I who will conduct a review of the clinical care provided to the baby's Mother while she was at HMP Bronzefield.
- The PPO will have unfettered access to all relevant material held both in hard copy and electronically. This includes classified material, physical and mental health information, internal reports and information originating from or held by other organisations e.g. contractors (or their sub-contractors) providing services to or on behalf of those within remit, if this is required for the purpose of the investigation.
- The PPO and her staff will have the right to interview all employees, prisoners and other individuals as required for the purposes of investigation and will be granted unfettered access to all such individuals. Where appropriate the PPO and the CDPT and the clinical reviewer commissioned by NHS E/I will conduct joint interviews.
- The PPO and her staff will have access to HMP Bronzefield, at times specified by the Ombudsman, for the purpose of conducting interviews with employees, prisoners and other individuals, for examining source materials (including those held electronically such as CCTV), and for pursuing other relevant inquiries in connection with the investigation.

Report

- The investigation should be undertaken with sufficient pace to enable resulting recommendations to be implemented as quickly and effectively as possible. It is expected, on the basis of current information, that the PPO will complete work and produce a final report to the Justice Secretary, setting out her findings of fact and recommendations, within 6 months.
- The Ombudsman will publish the final report on the PPO website.

Annex 3

The clinical review contains the following recommendations that are supported by the PPO and require a separate action plan:

- Sodexo and ASPH must establish a maternity pathway which follows best practice and which makes clear roles, responsibilities and systems of escalation. This must include a process for those women who fail to engage with services and should include access to psychological and psychiatric service assessment and support.
- ASPH and the CCG must review as a matter of urgency the resource available to provide this service. This should be informed by the issues identified in this report and by the experiences of the staff who work there at present. Any proposed changes should be subject to robust risk assessment and consideration of possible consequences.
- Sodexo healthcare must identify an appropriately qualified clinical midwifery lead to help them consider all aspects of perinatal care within HMP Bronzefield and to develop a more comprehensive pathway and to offer effective leadership.
- ASPH should ensure that midwives have the ability for remote access to the SystmOne records from their hospital base.
- The prison director and the Sodexo corporate head of healthcare must review the remit of the maternity liaison committee to ensure that it is appropriately focused on its task of improving quality and systems.
- A standing meeting should be established to provide a forum those who provide clinical care to pregnant women in HMP Bronzefield to discuss individual clinical cases. Attendance should include all areas of healthcare and the relevant discussion should be captured in the individual SystmOne record.
- Sodexo healthcare needs to establish a robust and reliable system for effective information sharing between the MBU and the healthcare team.
- The head of healthcare at HMP Bronzefield must review the oversight and support arrangements for MBU with a view to developing effective clinical leadership, clinically appropriate decision making and day to day operational clarity for staff.
- Sodexo should ensure that its operational systems are compliant with the intercollegiate document 'Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff'.²
- Sodexo healthcare should ensure that it has an effective clinical protocol to ensure that records of pregnant women who have a child protection plan for their unborn child are appropriately flagged according to national guidelines.
- Sodexo healthcare should ensure that minutes of child protection meetings and copies of child protection plans are obtained for all pregnant women where there is a child protection plan in place.
- The head of healthcare should ensure that in cases where safeguarding issues are identified consideration must be given to obtaining previous history via community medical records. Concerns with regard to information sharing should not stand in the way of effective safeguarding.

- The head of healthcare and the lead GP should review the system and revise the process for identifying community GPs, identification of the GP can be made via the “Lost GP” service if only incomplete details are held. The revised process should ensure that women are asked for details of their GP on more than one occasion to allow time for reflection and recall.
- The head of healthcare at HMP Bronzefield must establish a clear process for emergency responses involving births in the prison to ensure that immediate practical basic assistance can be provided.
- The prison director, the head of healthcare and the director of midwifery at ASPH must commission further training in relation to trauma informed care in action to be undertaken jointly by prison clinical staff and midwives. This training must be focused on prioritising the pregnant women’s needs above those of the general custodial environment, effective processes of working together and clear communication.
- The Board level oversight and governance from ASPH of the service it provides at the prison should be reviewed to provide assurance that clinical and other risks are assessed and mitigated where possible.
- ASPH must ensure that appropriate professional clinical supervision is provided for the midwives working at HMP Bronzefield. Supervision external to the team providing the service should be considered to counteract the effects of a small specialised and isolated service. Ideally this supervision should be external to the team and contain within it reflection on the effects of the custodial environment.
- ASPH must review and adapt the frequency and management of regular safeguarding supervision for their safeguarding specialists to develop their understanding of the wider safeguarding processes, identification of risk and raising concern whilst ensuring their compliance with the supervision process. Attendance at such supervision must be mandatory and regular appraisal of engagement with the process should be undertaken for each individual.
- The prison director, the Sodexo head of healthcare and the Director of Midwifery at ASPH should commission an independently facilitated session for their staff to enable a reflective discussion to consider all aspects of this case.
- Sodexo health and Cimmaron should consider the need for regular and consistent GP input to ensure a degree of clinical continuity. At the time of the incidents described the general practitioners were mainly peripatetic locums.
- The head of healthcare and the lead GP of the prison health service with input from the maternity service should review the role of the GP in the provision of maternity care and establish what this needs to be in a custodial environment.
- Sodexo health and Cimmaron should review the present system for discharge communication to community GPs in case where significant health and health related issues have occurred. In these cases a detailed discharge summary should be created and sent to the GP with a view to providing on-going care.
- The Local area CDR Team/CDOP should define how they will review the circumstances of all baby and child deaths (live and stillborn) occurring in HMP Bronzefield to identify learning and areas of good practice. Links should be made to any national fora to maximise learning.
- The Director of HMP Bronzefield and the Corporate leads for health and quality at Sodexo must review the safeguarding roles and responsibilities for babies living within the MBU for the times when the Nursery is not in operation in line with Working Together to Safeguard Children (HM Government, 2018) in order to

produce a clear policy and procedure for staff to follow. In addition, this review should consider the need for such approaches in the wider prison to ensure that staff understand their responsibilities in safeguarding unborn children.

- Sodexo healthcare should ensure that safeguarding children training for all staff working on the MBU is provided at an appropriate level and that training is mandatory for this staff group.
- Sodexo healthcare should ensure that all staff who work on MBU access annual paediatric specific resuscitation and basic first aid training.
- Sodexo healthcare should obtain external expert advice about the level of training and expertise that should be available in the prison in relation to neonatal and child resuscitation. This should include advice about the equipment that should be provided.
- Sodexo in discussion with NHSE and Surrey Heartlands CCG should consider the most direct method to deliver care to the mothers, babies and children living as a family unit within the MBU.

**Prisons &
Probation**

Ombudsman

Independent Investigations