

22 SEPTEMBER 2021

INVESTIGATION INTO BABY DEATH AT HMP BRONZEFIELD IDENTIFIES KEY FAILINGS

An 18-year-old woman should never have been allowed to give birth alone in her cell in Europe's largest women's prison, according to a report published today by Sue McAllister, the Prisons and Probation Ombudsman.

The PPO investigation into the baby's death, on 27 September 2019, highlighted a series of failings in care for Ms A in HMP Bronzefield. The investigation was commissioned in October 2019 by the Secretary of State for Justice.

A pathologist has been unable to determine whether Baby A was born alive or was stillborn, and no inquest has so far been held. However, the PPO report has been published to draw attention to a range of troubling weaknesses in the way Bronzefield and healthcare services handled Ms A's care.

Sue McAllister's report makes recommendations for improvements in dealing with pregnant prisoners at Bronzefield, particularly those like Ms A who are fearful of engaging with maternity care. The report's findings are relevant more widely across the prison service, and to health professionals working in women's prisons.

Ms A had a troubled and traumatic childhood and was in prison for the first time, facing a charge of robbery. She was vulnerable - "sad, angry and very scared" that

her baby would be taken away from her. She engaged "minimally or not at all" with the midwife team from Ashford and St Peter's Hospitals NHS Trust (ASPH) and all ante-natal care, including refusing to attend appointments for scans.

However, the report concluded that while there was a commitment at senior prison manager level to delivering trauma-informed care at Bronzefield, "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."

Sue McAllister said: "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."

Information sharing within and between the prison and health agencies was poor and the approach to managing Ms A was uncoordinated and no one responsible for her care had a full history of her pregnancy.

"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 focused on her baby rather than on her).

"There was a lack of clarity about Ms A's estimated delivery date." 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. "Staff working on Ms A's house block on 26/27 September did not know that Ms A might give birth imminently", and the response to her request for a nurse on 26 September "was completely inadequate".

"Prison healthcare staff were not sufficiently involved in maternity care in general and in Ms A's maternity care specifically" and "maternity services at Bronzefield were outdated and inadequate."

Overall, Sue McAllister said: "The midwife-centric model of maternity care in the community is not appropriate in a custodial setting." The report noted that at

Bronzefield "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."

Sue McAllister added: "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."

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Notes to editors

- 1. The report is available at 10.00am on 22 September 2021 at www.ppo.gov.uk
- 2. Embargoed copies of the report and action plans are attached to this news release.
- 3. The Prisons and Probation Ombudsman (PPO) is appointed by and reports directly to the Secretary of State for Justice. The Ombudsman's office is wholly independent of the services in remit, which include those provided by Her Majesty's Prison and Probation Service (HMPPS), the National Probation Service for England and Wales, the Community Rehabilitation Companies for England and Wales, Prisoner Escort and Custody Service, the Home Office (Immigration Enforcement), the Youth Custody Service, and those local authorities with secure children's homes. It is also operationally independent of, but sponsored by, the Ministry of Justice (MoJ).
- 4. The roles and responsibilities of the PPO are set out in the Terms of Reference (ToR), the latest version of which can be found in the appendices.
- 5. The PPO has three main investigative duties:
 - complaints made by prisoners, young people in detention, offenders under probation supervision and individuals detained under immigration powers (detained individuals)
 - o deaths of prisoners, young people in detention, approved premises' residents and detained individuals due to any cause
 - using the PPO's discretionary powers, the investigation of deaths of recently released prisoners
- 6. 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. There is also a separate Mother and Baby Unit (MBU) providing accommodation for up to 12 prisoners and their babies up to the age of 18 months.
- 7. The prison is operated by Sodexo Justice Services (SJS) who provide primary healthcare. Sodexo directly employs nurses and healthcare assistants and has a corporate contract to employ GPs from Cimarron UK.
- 8. The most recent full inspection of Bronzefield by HM Inspectorate of Prisons was in November/December 2018 and <u>published</u> in 2019.
- 9. Please contact John Steele on 07880 787452, or at john.steele@justice.gov.uk if you would like more information