

A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

**Investigation into the death of a woman, a prisoner at
HMP New Hall, in February 2014**

Our Vision

*'To be a leading, independent investigatory body,
a model to others, that makes a significant contribution to
safer, fairer custody and offender supervision'*

This is the investigation report into the death of a woman, who died from severe blood loss in February 2014, after cutting her arms at HMP New Hall. She was 51 years old. I offer my condolences to her family and friends.

A review of the care and treatment the woman received at New Hall was undertaken. Staff at New Hall cooperated fully with this investigation.

The woman was remanded to New Hall on 9 July 2012, charged with grievous bodily harm and wounding, and was later sentenced to six years and nine months in prison. She had been in prison before. She frequently saw the healthcare team at New Hall, and was receiving treatment from three different hospital consultants for her medical conditions. No one ever regarded her as being at risk of suicide or self-harm.

In February 2014 officers found that the woman had cut her arm severely and had lost a lot of blood. They called for help and the healthcare staff responded quickly and began emergency treatment. An officer called an emergency medical code and the control room then called an ambulance immediately. Paramedics took her to hospital, but a doctor confirmed that she had died.

After the woman's death, other prisoners told staff that she might have been using cocaine and synthetic cannabis, known as Spice. The toxicology report conducted as part of the post-mortem did not reveal any traces of illegal drugs, but the clinical reviewer noted that traces of cocaine would not remain in the body long and that there was no specific test for Spice. The clinical reviewer said that a combination of these drugs would have increased the possibility of her having a rapid onset psychotic episode, which might have caused her actions. Otherwise, there is little explanation for her actions, which seemed entirely out of character. She had never given any indication to staff, other prisoners or her family that she was at risk of harming herself.

I am satisfied that the woman received appropriate care at New Hall and that staff at the prison could not have foreseen or prevented her tragic death.

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

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SUMMARY

1. The woman was remanded to HMP New Hall on 9 July 2012, charged with grievous bodily harm and wounding. She had been in prison before. She was convicted on 28 February 2013, and sentenced to six years and nine months.
2. The woman had several long-term medical conditions and had frequent interventions from the healthcare team at New Hall and was under the care of three hospital consultants. She never gave any indication of being at risk of suicide or self-harm.
3. In February 2014 officers heard a disturbance in the woman's cell and found that she had severely cut her arm and lost a lot of blood. Healthcare staff responded, began cardiopulmonary resuscitation and called for an emergency ambulance. Paramedics arrived and took her to hospital, where a doctor confirmed that she had died.
4. We do not think that the prison staff could have predicted or prevented the woman's actions. She never showed any sign during her sentence that she might harm herself or was at risk of suicide. Her actions were sudden and unexpected. After her death, some prisoners said that she had been using synthetic cannabis (known as Spice) and cocaine. We have not found any evidence that staff were aware of this before her death, and the toxicology report conducted as part of the post-mortem examination did not reveal any traces of illicit drugs.
5. We are satisfied that the woman received appropriate care at New Hall. The emergency response when she was found to have self-harmed in her cell was swift and appropriate. Ideally a code red should have been used immediately but healthcare staff attended at once and an emergency code was used quickly after that.

THE INVESTIGATION PROCESS

6. The investigator visited New Hall on 20 February 2014 and obtained the woman's prison records. He issued notices to staff and prisoners inviting anyone with information to contact him. No one responded. He met the Governor and interviewed ten members of staff and two prisoners at New Hall in March. He wrote to the Governor about the preliminary findings of the investigation.
7. NHS England appointed a clinical reviewer to review the woman's clinical care at HMP New Hall.
8. The investigator informed Her Majesty's Coroner for West Yorkshire Eastern District of the investigation and requested a copy of the post-mortem report. Our investigation was suspended for several months while we waited for the post-mortem report, which was delayed until the pathologist received a toxicology report. We received the toxicology report on 11 November 2014. We have sent this investigation report to the Coroner.
9. The investigator met the woman's family on 20 March to inform them about the investigation and to invite them to identify issues they wanted the investigation to consider. The family wanted information about:
 - The medication she was prescribed and whether it was sufficient for her needs.
 - Events on 12 February, specifically after a noise was heard in her cell.
 - Whether she had given any indication that she intended to harm herself.
 - Whether she had made an application for compassionate release.

The family received a copy of the draft report. The solicitor representing the family wrote to us raising a number of questions that do not impact on the factual accuracy of this report. We have provided clarification by way of separate correspondence to the solicitor.

HMP NEW HALL

10. HMP New Hall, near Wakefield, holds up to 446 women. Spectrum Community Health provides healthcare services at the prison.

HM Inspectorate of Prisons

11. The most recent inspection of New Hall was in February 2012. Inspectors found that improved safety, good mental health provision and better drug treatment had all contributed to a significant reduction in self-harm and the number of women being managed under suicide and self-harm prevention procedures since the previous inspection. Inspectors noted that while the positive drug test rate was within target, many prisoners said drugs were easy to obtain. Inspectors recommended a more strategic approach to reducing the supply of drugs.

Independent Monitoring Board

12. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community to help ensure that prisoners are treated fairly and decently. In its most recent report for the year ending February 2013, the IMB reported that self-harm continued to be an issue at New Hall and that staff were encouraged to make appropriate assessments to support and monitor prisoners assessed as at risk of harming themselves.

Previous deaths at New Hall

13. There have been six self-inflicted deaths at New Hall since the PPO began investigating deaths in prisons in 2004: three in 2004, one in 2005, one in 2006 and the other in 2011. None of these deaths had any similarities with the circumstances of the woman's death.

KEY EVENTS

14. The woman was remanded to New Hall on 9 July 2012, after being charged with grievous bodily harm and wounding. She had been in prison before. She was a smoker and used drugs. She was convicted on 28 February 2013 and sentenced to six years and nine months.
15. The woman had frequent contact with healthcare staff at New Hall. She suffered from chronic obstructive pulmonary disease (COPD - lung disease), Reynaud's disease, lupus and hearing loss in her left ear. She was under the care of three hospital consultants, a rheumatologist, a respiratory consultant and an ear, nose and throat (ENT) consultant.
16. At the time of her death, the woman used the following prescribed medication: hydroxychloroquine, prednisolone and alendronic (for lupus), mirtazapine (for depression), seretide, salbutamol, spiriva, fluticasone and carbocisteine (for COPD), hyoscine butylbromide (for stomach spasms), lansoprazole (which reduces stomach acid), and ibuprofen (pain relief gel). She received her medication from nurses three times a day.
17. When the woman arrived at New Hall, she began started a methadone drug detoxification programme, which she successfully completed in December 2013.
18. A prison doctor told the investigator that she last saw the woman on 7 January 2014 when her symptoms of COPD and lupus had been stable for some time. The doctor said that the woman smoked heavily and she continued to encourage her to give up smoking as this would help her COPD. She said that the woman had been prescribed antidepressants in the community. She had continued this prescription in prison.
19. An officer described the woman as a very bubbly character, full of fun, pleasant and very well liked. The officer said that the woman had been in New Hall several times before and would readily ask officers for help if she had any problems. The officer was aware that her health was not good, as she talked about her medical conditions and how they affected her.
20. Because of her poor health, the woman did not have a prison job. An officer told the investigator that staff left her cell door open in the mornings and afternoons, but she usually stayed in bed or watched television. She said that the woman was good at art and crafts and enjoyed making cards and drawing. She would often make things with, and for, other prisoners on the wing.
21. The woman had never self-harmed in prison and staff had never assessed her as at risk of suicide and self-harm. There is no record that she indicated to family, friends, officers or the healthcare team that she had any thoughts of suicide or self-harm. Prison records show that the last telephone call she made was on the evening of 11 February, when she called her mother. Her

mother told the investigator that during this call, she sounded her usual self. They had talked about their next visit.

22. The investigator interviewed Prisoner A, who lived on the same wing as the woman and who had known her for over 10 years. Her cell was immediately above the woman's, and she said that they spoke every day. The prisoner said the woman had seemed a bit fed up in the days before her death and she had spent a lot of time looking at old photographs and talking about her family. However, the prisoner said that the woman did not give any indication that she wanted to harm herself or take her own life. She said that the woman had chatted to her during the evening of 11 February and had seemed happier and said that she had arranged a visit with her family.
23. Prisoner B, who was on the same wing as the woman, said that she spoke to her every day. She said that on the evening of 11 February, the woman told her that a friend had sent her some crack cocaine in the post, and showed her a red envelope which some white substance on it. She did not name the friend.

Events leading up to the incident

24. Prisoner A saw the woman when their cells were unlocked in the morning. She said that the woman had a big smile on her face and was quite bubbly. During the morning, the woman chatted to an officer, who told the investigator that she was in good spirits and had tidied her cell. The officer saw nothing to suggest that she had any thoughts of suicide or self-harm.
25. Prisoner A told the investigator that she saw the woman chatting and laughing with other women during lunch in the dining hall. Afterwards, staff locked prisoners in their cells at 12.00pm. Officers were off the wing between 12.00pm to 2.00pm, as they had their monthly occupational health session that day after lunch.
26. Prisoner C told the investigator that she had been on the same wing as the woman for three weeks and lived in the cell next to her. She said that the woman was a fun-loving person who got on well with everyone on the wing. She said that she last saw her at lunch on the day of her death and she was her usual self. Prisoner B said that she last saw her in the dining hall and medication queue, when she seemed fine and was laughing and joking with other women prisoners.
27. At approx 2.20pm, two officers were in the wing office when they heard what they described as singing coming from the woman's cell. The noise quickly changed and became more loud and aggressive, so the officers went to investigate. Officer A opened the observation flap and although it was dark (the curtains were drawn and the lights were off) she could see that the woman was lying on the bed. She told the investigator that she thought that that the woman was having a bad dream. She opened the cell door and turned on the light, and found blood on the walls and the floor and all over the woman. Officer B radioed for urgent medical assistance. Officer A ran to the

healthcare unit, which was just yards away from the cell, to get as many nurses as possible to come.

28. Three nurses responded immediately. They examined the woman and found that she had made a large deep cut in her right arm and had severely damaged the blood vessels. The wound was no longer bleeding. Nurses said that at first she appeared to be fighting to push the staff off her. A Supervising Officer (SO) responded to the initial radio message and, when she arrived at the cell radioed a code red (the recognised emergency call when someone is found with blood loss and an emergency ambulance is required). The control room called an ambulance immediately. The nurses gave her oxygen, dressed her wound and attached a defibrillator. Her breathing became erratic and, at one point, she stopped breathing, but the staff managed to resuscitate her.
29. Ambulance Service records show that the 999 call was made at 2.22pm. The first responder arrived at New Hall at 2.35pm and the paramedics arrived at 2.42pm. After treating the woman, they decided to take her to hospital. They left New Hall at 3.43pm, and arrived at the hospital at 4.00pm. Two officers accompanied her to the hospital. After a period of assessment and treatment, hospital doctors withdrew treatment at 4.50pm, as there was nothing that could be done to save her. She died at 5.15pm.

Contact with the woman's family

30. Because of the seriousness of the woman's condition, New Hall sent a family liaison officer and a prison chaplain to inform her mother that she had been taken to hospital. Before they arrived at her mother's home, they learnt that she had died. They broke the news of her death to her mother and offered condolences. New Hall kept in contact with the family for ongoing support and offered financial assistance towards the funeral expenses, in line with national guidance.

Support for staff and prisoners

31. On the early evening of 12 February, managers held a debrief for the staff involved in the emergency response to discuss what had happened. They offered the support of the prison's care team.
32. Officers and members of the chaplaincy team supported prisoners affected by the woman's death. Staff reviewed prisoners assessed as at risk of suicide or self-harm in case they had been adversely affected by her death.
33. After the woman's death, several prisoners told officers that she had used drugs and Spice (a synthetic cannabis) on the day of her death.

Post-mortem and toxicology

34. A consultant forensic pathologist conducted a post-mortem examination and gave the cause of the woman's death as a haemorrhage, as a result of an

incised injury to the upper right arm. He noted that he had not received a toxicology report five months after he had requested one, but if the report contained significant findings, he would amend the post-mortem report.

35. We received the toxicology report on 11 November 2014. Traces of hydroxychloroquine and mirtazapine were found, in line with therapeutic doses. There was no trace of other drugs (except caffeine and nicotine) or alcohol.

ISSUES

Assessment of risk of suicide and self-harm

36. Assessment, Care in Custody and Teamwork (ACCT) is the care planning system the Prison Service uses to support prisoners at risk of suicide or self-harm. The purpose of the ACCT process is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. We have considered whether staff should have identified the woman as at risk of suicide and self-harm and used ACCT procedures to support her.
37. Staff judgement is fundamental to the ACCT system. At its core, the system relies on staff using their experience and skills, as well as local and national assessment tools, to determine risk. A prisoner's presentation is obviously important and reveals something of their level of risk, but all risk factors must be collated and considered to ensure that a prisoner's level of risk is judged holistically.
38. In the woman's case, she had few obvious risk factors which would have led anyone to consider that she was at risk of suicide or self-harm after she arrived at New Hall in 2012. Although she had risk factors such as physical illness and a history of depression and substance misuse, she had never previously self-harmed in prison. She gave no indication to staff at New Hall, other prisoners or her family that she had thoughts of self-harm or taking her own life. During her current sentence, she had regular telephone contact with her family and received visits. We are unaware of any event in her life at the time that might have triggered her act of self-harm.
39. We have considered whether the woman had been bullied while at New Hall. The investigator asked the security department if there was any intelligence that directly linked her to being the victim of bullying, but found no evidence that this was the case. She seemed to have been popular and respected by staff and other women prisoners.
40. We have not found any evidence that staff should have been concerned about the woman's state of mind, and have not found any reason to explain her actions on 12 February. We do not consider that staff at New Hall could have predicted or prevented her death.

Clinical care

41. The clinical reviewer assessed the care that the woman received at New Hall. He found that the care provided by the medical and nursing staff at New Hall for both her long-term conditions and unrelated acute illnesses, was excellent. She had appropriate medical investigations both in prison and hospital settings, and interventions were timely and not hindered by her being in prison. He noted that there was excellent communication between all those involved in her care.

42. The clinical reviewer commented that the treatment offered to the woman for her drug misuse was appropriate. She successfully completed a methadone detoxification programme.
43. The clinical reviewer also found that the woman's mental health and emotional needs were well catered for at New Hall. She had good access to health care and mental health support and her regular contact with nursing and medical staff gave them the opportunity to detect any change in her mood or personality. He found no documentary evidence in the clinical records that her mood or mental well being deteriorated in the weeks before her death or that she had suicidal thoughts or had contemplated self-harm.
44. The significant episode of self-harm on 12 February, which led to the woman's death, was totally unexpected and without any warning. There is anecdotal evidence that she might have relapsed into taking illicit drugs, including Spice and cocaine. The clinical reviewer noted that if she had taken cocaine and Spice, it was possible that she had developed a rapid onset psychotic episode that might have led to her sudden act of self-harm. The toxicology found no evidence of illicit drugs. However, the clinical reviewer noted that there was no test for Spice.
45. We are satisfied that the care that the woman received at New Hall was equivalent to that expected of an NHS patient in the community, and her death could not have been predicted or prevented.

Emergency response

46. When Officer A found the woman in her cell covered in blood at 2.20pm, Officer B radioed for urgent medical assistance. A SO radioed code red at 2.22pm, and the control room then called an ambulance immediately. Paramedics reached the cell at 2.42pm. Paramedics took her to hospital, where she later died at 5.15pm. The clinical reviewer commented that the massive blood loss at the time she was found made recovery impossible. The lack of sufficient volume of circulating blood would have starved the major organs of oxygen which would have led to critical and irreversible damage within minutes.
47. Although staff did not call a code red emergency immediately, as we would have expected, there was only a very slight delay. We understand that the officers were confronted with a shocking situation and their immediate response was to get nurses to attend as quickly as possible. Once the code red was called the control room called an ambulance immediately. The clinical reviewer said that the emergency response from nursing staff at New Hall was good. We are satisfied that New Hall has an appropriate medical emergency response code protocol and that the very brief delay did not affect the outcome. In these circumstances we make no recommendation.

Compassionate release

48. The woman's family told the investigator that they believed she had applied for compassionate release on health grounds. Prisoners can be released from custody before their sentence has expired on compassionate grounds for medical reasons. This is usually when they are suffering from a terminal illness and have a life expectancy of less than three months.

49. The Head of Offender Management at New Hall confirmed that the woman had not applied to be considered for compassionate release. He said that her COPD was a progressive disease and her health would deteriorate over a seven to ten year period. We are satisfied that if she had made an application for compassionate release during her current sentence it would have been very unlikely to have met the eligibility criteria.