

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Ms Michelle Barnes a prisoner at HMP Low Newton on 16 December 2015

**A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE**



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

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

Ms Michelle Barnes was found hanged in her cell at HMP Low Newton on 16 December 2015, five days after giving birth. She was 33 years old. I offer my condolences to her family and friends.

Ms Barnes had a history of mental health problems, drug misuse, abusive relationships and long term self-harm. She had never been in prison before and, when she arrived at Low Newton, she found she was pregnant. Social services applied for an interim care order when her baby was born, with the intention that the baby would be fostered and then adopted. Many professionals were involved in Ms Barnes' care, including her offender supervisor, mental health nurse, substance misuse worker, social worker and midwife. There is much to commend about individual examples of care Ms Barnes received before her child was born, but there was little joint working.

Separation at birth from a child who is taken into care is traumatic for any mother, and particularly for a woman in prison. Despite good support before the birth, I found little evidence of multidisciplinary planning to support Ms Barnes' during the postnatal period. Her care was uncoordinated and ad hoc. None of the professionals who had previously been involved checked her and a decision to allow her to visit and feed her baby in hospital was suddenly reversed without proper consideration or explanation. Communication between prison staff and other agencies was poor.

To compound matters, Ms Barnes' risk of suicide was not managed well. She was monitored as at risk throughout the latter stages of her pregnancy and staff unaccountably decided to end suicide and self-harm monitoring before the birth, even though Ms Barnes' distress about the imminent removal of her baby had been identified as a trigger for potential suicide. No one identified the postnatal risk, and an opportunity to begin monitoring again was missed at a post-closure review.

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

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Summary

Events

1. Ms Michelle Barnes had a history of mental health problems, self-harm and significant substance misuse. On 25 June 2015, she was sentenced to two years in prison for drug offences. She was taken to HMP Low Newton and found out she was pregnant at an initial health screen. Staff regarded her as at risk of suicide and self-harm and monitored her under Prison Service suicide and self-harm prevention procedures, known as ACCT for the next month. Ms Barnes was prescribed methadone to treat opiate dependency and a substance misuse worker and a mental health nurse saw her regularly. A psychiatrist prescribed antipsychotic medication. She also had frequent visits from a community midwife. She was allocated an offender supervisor, who also acted as the mother and baby unit liaison officer.
2. Ms Barnes' other children had previously been placed in her parents' care because of her chaotic lifestyle. Her local authority allocated a social worker to protect the interests of her unborn baby and held a series of child protection meetings at Low Newton. From an early stage, social services told Ms Barnes that they intended to apply to the family court to have the baby fostered and eventually adopted.
3. In late September, staff began to monitor Ms Barnes under ACCT procedures again, because she was distressed about the proposed removal of her child. On 30 November, a supervising officer at a case review with only an officer present, decided to end this monitoring. On 7 December, a supervising officer had some concerns about Ms Barnes but did not restart monitoring. On 11 December, Ms Barnes gave birth to her baby in hospital. Social services were granted an interim care order the same day.
4. On 13 December, Ms Barnes was discharged from hospital. She was taken back to the hospital to feed her baby on 14 December but the next day, prison managers decided to stop these visits, without any explanation or discussion with Ms Barnes or the relevant agencies. On the evening of 16 December, Ms Barnes had appeared upset. At 11.00pm, an officer checked to see if she was more settled, but got no response and could not see her. He called the night manager who went into the cell and found Ms Barnes had hanged herself. Staff began cardiopulmonary resuscitation and called an ambulance. Paramedics arrived and took over emergency treatment but shortly afterwards, recorded that Ms Barnes had died.

Findings

5. The different teams working with Ms Barnes each offered her care of an acceptable or good standard before she gave birth. However, we found no evidence of any joined up, multidisciplinary planning to support her through the postnatal period when she was separated from her baby. Nobody identified and acted on Ms Barnes' evident risk when she returned from hospital after giving birth and there was a lack of coordinated support. Decisions were made on an ad hoc basis, the prison made a unilateral decision to stop Ms Barnes visiting her

baby and communication between agencies broke down. No one discussed the decision with Ms Barnes and the member of staff who delivered the message was unaware of the background or the implications for Ms Barnes.

6. We have serious concerns about the quality of ACCT procedures. Although Ms Barnes was pregnant and had mental health and substance misuse problems, there were no healthcare staff at the first or the last case review, which ended ACCT monitoring. Case reviews did not involve some of the professionals who knew Ms Barnes best, only one was multidisciplinary and there was little continuity and consistency of care management. Risk was not properly assessed at each case review and the staff assessed her risk as low, even after an incident of self-harm. Care map actions were not specific and meaningful and only one of five different case managers updated the care map. The case manager who ended ACCT monitoring ignored the identified trigger for suicide and self-harm, which was Ms Barnes' anxiety about the removal of her child. A supervising officer at a post-closure review did not begin ACCT procedures again, even though he was concerned about Ms Barnes.
7. Low Newton's safer custody policy does not address the risks associated with pregnancy, the postnatal period or a baby being taken into care. Contrary to the prison's local violence reduction policy, incidents of potential bullying were not investigated.
8. Information sharing among healthcare staff was poor. Psychologists on Ms Barnes' unit kept a separate record of contact that healthcare staff could not read; visiting midwives could not see Ms Barnes' complete medical record; and GPs did not attend the daily healthcare briefing.
9. There were some deficiencies in the emergency response, including a delay of four minutes before calling an ambulance.

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.

- The Head of Healthcare should ensure that:
 - PIPE psychologists record their contact with women in the SystemOne medical record.
 - Community midwives are able to view the complete SystemOne medical record and make relevant entries in the record.
 - GPs attend the morning meeting where possible.

- The Governor and Head of Healthcare should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidance, including in particular:
 - Holding multi-disciplinary reviews with continuity of case management and involving all staff who can contribute to the care of a prisoner at risk, with healthcare staff attending at least all first case reviews.
 - Case reviews taking full account of all known risk factors, including reviewing the recorded triggers when determining a prisoner's risk of suicide or self-harm and fully recording the reasons for decisions.
 - Using the enhanced case review process when appropriate.
 - Setting effective care map objectives, which are specific and meaningful, identifying who is responsible for completing them and reviewing them at each case review.
 - Holding post-closure interviews in line with PSI 64/2011 and reopening ACCTs when there is an indication of continuing or additional risk.

- The Governor should ensure that incidents of alleged bullying are investigated in line with the local violence reduction policy.

- The Governor should ensure that all staff are aware of PSI 03/2013 and local guidance and understand their responsibilities during medical emergencies, including that staff use the appropriate code to communicate a medical emergency immediately and that staff bring all relevant emergency equipment promptly to the scene.

The Investigation Process

10. The investigator issued notices to staff and prisoners at HMP Low Newton informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
11. The investigator visited Low Newton on 6 January and obtained copies of relevant extracts from Ms Barnes' prison and medical records.
12. NHS England commissioned a clinical reviewer to review Ms Barnes' clinical care at the prison.
13. The investigator interviewed prison and healthcare staff, community midwives, Ms Barnes' baby's social worker and a prisoner in February and March 2016. Some of the interviews were conducted jointly with the clinical reviewer.
14. We informed HM Coroner for Durham of the investigation, who gave us a copy of the post-mortem report. We have sent the coroner a copy of this report.
15. One of the Ombudsman's family liaison officers contacted Ms Barnes' parents to explain the investigation and to ask if they had any matters they wanted the investigation to consider. They wanted to know:
 - What consideration had been given to monitoring Ms Barnes' risk of suicide and self-harm at the time she died.
 - What exactly Ms Barnes had been told about her child being placed in the care of the local authority and when.
 - Why Ms Barnes had been allowed to breastfeed and bond with her baby when the baby was going to be placed into care.
16. Ms Barnes' family received a copy of the initial report. They pointed out a factual inaccuracy. This report has been amended accordingly. Ms Barnes' family also raised a number of issues that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

Background Information

HMP Low Newton

17. HMP Low Newton near Durham holds up to 329 women. The population includes women on remand, prisoners serving short and long sentences, and some high security prisoners.
18. G4S is the main healthcare provider at Low Newton responsible for 24 hour primary care, clinical care for substance misuse and the administration. Tees, Esk and Wear Valleys NHS Foundation Trust provide primary and secondary mental healthcare, and subcontract some services to two other providers, Rethink and Mind. Spectrum provide GP and pharmacy services. There is separate provision for dental and optician services. The different providers meet once a month at an operational governance meeting chaired by the Governor.
19. All pregnant prisoners are referred to the University Hospital of North Durham. County Durham and Darlington NHS Foundation Trust community midwives visit the prison each Tuesday.
20. The PIPE (Psychologically Informed Planned Environment) unit is jointly commissioned by the National Offender Management Service and the NHS, and provides a therapeutic and structured environment for women with personality disorders. The unit is staffed by general prison officers, two (soon to be four) specially trained PIPE prison officers seconded from their normal roles and psychologists employed by Tees, Esk and Wear Valleys NHS Foundation Trust. The unit is largely separate from the rest of the prison. Women selected for the PIPE unit stay a minimum of three months.

HM Inspectorate of Prisons

21. The most recent inspection of Low Newton was in October 2014. Inspectors found a complex prison holding a challenging and very vulnerable population. There were extremely high levels of need, with half of the women needing mental health treatment. The inspection team noted that, in many ways, the service the prison offered more closely resembled a hospital than a prison. Mental health services were generally very good. Pregnancy and antenatal care was good. Inspectors described the care provided in the PIPE unit as groundbreaking and outstanding. Levels of care for women at risk of suicide and self-harm were generally good. Demand for substance misuse services was very high. The inspectors found that staff were humane and caring. They commented that a more coordinated approach was needed to manage women with complex needs.

Independent Monitoring Board

22. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to February 2015, the IMB reported that Low Newton offered a safe and supportive environment and that there was a good atmosphere in the prison. The Board described the support available for women at risk of suicide and self-harm as robust.

Previous deaths at HMP Low Newton

23. Since 2010, we have investigated four deaths at Low Newton. Two were from natural causes, one was caused by an apparent overdose and one was self-inflicted. Our investigation into the self-inflicted death in December 2013 found that the mental health team did not have a contingency plan when the woman's keyworker was absent. Mental health nurses were not sufficiently involved in ACCT case reviews or important decisions about the woman's level of risk. ACCT case reviews did not fully consider new information about increased risk of suicide or self-harm. ACCT care maps were not meaningful or well managed and ACCT procedures ended before all care map actions had been completed. Staff did not follow national instructions for medical emergencies. These issues also arose in this investigation.

Assessment, Care in Custody and Teamwork

24. 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 ACCT 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. Checks should be irregular to prevent the prisoner anticipating when they will occur. Part of the ACCT process involves drawing up a care map to identify the prisoner's most urgent issues and how they will be met. Regular multi-disciplinary reviews should be held. The ACCT plan should not be closed until all of the actions on the care map have been completed. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Key Events

25. On 25 June 2015, Ms Michelle Barnes was sentenced to two years in prison for conspiring to supply crack cocaine. She had a longstanding substance misuse problem but had not been to prison before. Her chaotic lifestyle meant that the family court had appointed her parents as the legal guardians of her two children.
26. Ms Barnes' escort record noted that she had a history of self-harm by cutting and suffered from schizophrenia, bipolar disorder, post-traumatic stress disorder and psychosis. Escort staff attached a self-harm warning form to the escort record, which stated that Ms Barnes had cut her arms in the last week and had taken an overdose of medication a month previously, but said she had no current thoughts of harming herself.
27. Ms Barnes was taken to HMP Low Newton. An officer interviewed Ms Barnes in reception and noted her history of self-harm and mental health problems. At an initial health assessment, a nurse noted Ms Barnes' extensive history of self-harm. She said that she was under the care of her community mental health team, was due to see a psychiatrist and was currently prescribed olanzapine (an antipsychotic), pregabalin (for anxiety), diazepam (for anxiety) and venlafaxine (an antidepressant). Ms Barnes said that she misused heroin, crack cocaine and benzodiazepines. He referred her to the substance misuse team, the mental health team and the GP and began ACCT suicide and self-harm prevention procedures. Ms Barnes had a routine pregnancy test, which indicated she was pregnant. She was surprised about this.
28. A GP assessed Ms Barnes and did not consider she was suffering from drug withdrawal symptoms, but prescribed symptom relief medication as a precaution. He decided not to prescribe any other medication until he received Ms Barnes' community records. Ms Barnes was given a cell in the prison's substance misuse unit.
29. On 26 June, a GP examined Ms Barnes and booked an appointment with a midwife and a scan to determine her due date. She prescribed methadone (an opiate substitute), 15ml each day. (Pregnant women already dependent on opiates are maintained on methadone to prevent withdrawal symptoms and potential miscarriage.) The GP requested Ms Barnes' community records so she could prescribe appropriate medication for her mental health.
30. Also on 26 June, a nurse assessed Ms Barnes' mental health. Ms Barnes said that in 2012, she had been 'sectioned' (detained in hospital under the Mental Health Act 1983). She had self-harmed since the age of 13, mostly by burning and cutting her arms, but had also attempted suicide by overdose and by trying to hang herself. She said she could hear six different voices in her head. The nurse added Ms Barnes to her caseload and referred her to the psychiatrist.
31. The nurse telephoned Ms Barnes' community mental health team and was told that she was managed under the NHS Care Programme Approach (a way of coordinating services for patients with complex mental health needs) and had a psychiatrist. Her engagement with mental health services was sporadic and she had last attended an appointment in November 2014. She had no official diagnosis but met the criteria for recurrent depression with traits of emotionally

unstable personality disorder. A member of staff from the community mental health team confirmed that Ms Barnes had a long history of deliberate self-harm and impulsive behaviour and gave details of her medication.

32. The same day, a supervising officer assessed Ms Barnes as part of ACCT procedures, and noted she had week-old self-inflicted cuts on her wrists. Ms Barnes said that she usually self-harmed by cutting or burning herself. She described numerous suicide attempts (including attempted hanging and a recent overdose) triggered by stress. Ms Barnes said she had no current thoughts of suicide or self-harm and her children were her reason for living.
33. Afterwards, a supervising officer chaired the first ACCT case review, attended by Ms Barnes, a nurse, the mobility officer and another supervising officer. The review assessed Ms Barnes' risk of harm to herself and the likelihood of further risk behaviours as low. The Chair entered three issues in the ACCT care map: first time in custody coupled with a history of self-harm in the community, mental health issues, and pregnancy. (The care map should reflect the prisoner's needs, level of risk, and the triggers for their distress. It should aim to address the issues identified in the ACCT assessment interview and set actions designed to address the issues and reduce the prisoner's risk.)
34. Ms Barnes was referred to the Drug and Alcohol Recovery Team (DART), who offer support for prisoners with substance misuse problems. On the evening of 26 June, a GP reviewed Ms Barnes. As Ms Barnes had symptoms of opiate withdrawal, the GP increased the dose of methadone to 20ml each day.
35. On 27 June, Ms Barnes said that she kept hitting her head to make the voices she was hearing go away and asked for antipsychotic medication. A GP prescribed 5mg of olanzapine daily until she could have a psychiatric review. (Pregnant women are given low doses of mental health medication, in case these affect the baby.) The GP increased Ms Barnes' dose of methadone to 25ml daily. That evening, Ms Barnes punched herself in the face because she was hearing voices.
36. On 29 June, the GP further increased Ms Barnes' methadone dose to 35ml daily and, after checking her community records, prescribed a low dose of diazepam. On 30 June, a midwife saw Ms Barnes. The GP prescribed 45ml of methadone daily because Ms Barnes was still suffering opiate withdrawal symptoms.
37. On 1 July, a psychiatrist reviewed Ms Barnes who described a history of manic depression, bipolar affective disorder, schizophrenia with psychosis, post-traumatic stress disorder, panic and anxiety, anorexia and body dysmorphia. Her previous relationships had all been abusive. She harmed herself as a form of release from tension but sometimes with the intent of killing herself. She said she heard six different voices arguing in her head. The psychiatrist found no evidence of a mental illness but identified traits of borderline and antisocial personality disorder and thought that Ms Barnes' drug use had caused her mental disorder. That day, Ms Barnes was discharged from the substance misuse unit and moved to E2 landing. She was now stable on 45ml methadone daily.

38. On 2 July, Ms Barnes' offender supervisor (who helped prisoners meet their sentence plan targets) recorded a resettlement plan setting out five issues: addressing drug misuse with the DART team, working with the mental health team, her pregnancy, accommodation after release and employment in prison. (He was also the Mother and Baby Unit Liaison Officer for pregnant prisoners.)
39. On 3 July, a supervising officer chaired the second ACCT case review, which assessed Ms Barnes' risk as low. A nurse had briefed the supervising officer beforehand, but there were no healthcare staff at the review. Ms Barnes moved to C2 landing that day and the nurse referred her to her local social services team because of concerns about her unborn baby. On 7 July, the offender supervisor interviewed Ms Barnes and gave her information about mother and baby units in other prisons, where she might be able to live after her baby was born. On 8 July, the nurse created a mental health care plan.
40. On 10 July, Ms Barnes was taken to hospital for a scan, and given an expected delivery date of 26 December. The same day, a supervising officer chaired the third ACCT case review with Ms Barnes, a nurse and a member of the safer custody team. Ms Barnes said she had thoughts of harming herself but had made no plans, and the case review assessed her risk as low. On 12 July, Ms Barnes moved to C1 landing. That day, staff spotted her trying to avoid swallowing her diazepam when she was in the medication queue. (Prisoners sometimes try to store up or trade their medication). On 13 July, her substance misuse healthcare support worker saw her. (The worker specialises in helping pregnant women with significant drug misuse issues.)
41. On 16 July, a supervising officer held the fourth ACCT case review with no other member of staff present. He got a verbal contribution from the mental health team first. Ms Barnes said that she had no current thoughts of suicide or self-harm and the review assessed her risk as low. The supervising officer added an issue to the care map about Ms Barnes not taking her mental health medication. On 17 July, a nurse reviewed Ms Barnes, who said she was happier after moving to C1 landing. On 21 July, Ms Barnes received a letter from social services about her unborn baby, which upset her.
42. On 23 July, a supervising officer chaired the fifth ACCT case review with a member of the safer custody team. Ms Barnes said she had no thoughts of suicide or self-harm and was engaging with the mental health team. The review assessed her risk as low and ended ACCT procedures. The supervising officer updated the care map and gave Ms Barnes an ACCT closure support plan outlining sources of support and alternatives to self-harm.
43. On 28 July, a nurse reviewed Ms Barnes' mental health. Later that day, the social worker for Ms Barnes' unborn baby visited her. She was the social worker who had placed Ms Barnes' other children with her parents. She told Ms Barnes that social services would apply to the family court for her baby to be taken into local authority care because her lifestyle meant she could not prioritise her child's needs above her own. She told the offender supervisor that social services would not support an application for Ms Barnes to keep the child and move to a prison mother and baby unit.

44. On 29 July, the substance misuse healthcare support worker saw Ms Barnes, who was distressed that her baby might be taken straight into care. On 30 July, a supervising officer held an ACCT post-closure review with Ms Barnes. She said that things had settled down and she would speak to staff if she had problems. On 4 August, Ms Barnes' midwife saw her. The same day, a GP reviewed her medication and continued her prescriptions for methadone, diazepam and olanzapine. On 6 August, Ms Barnes went to hospital for an antenatal check up.
45. On 17 August, a nurse reviewed Ms Barnes, who said she was stressed about the thought of her unborn baby being taken into care and losing her accommodation. However, she said that her mental health was the most stable it had been for a long time. On 18 August, Ms Barnes' father and eldest daughter visited her. On 29 August, Ms Barnes' friends became worried about her, so a nurse reviewed her on 30 August. She talked about her fears of having her baby removed and became tearful. She said that she hated methadone but would stay on it for the sake of her child. On 1 September, the midwife reviewed Ms Barnes.
46. On 9 September, the social worker chaired an initial child protection conference at Low Newton. Ms Barnes, her offender supervisor, a nurse, a midwife and the prison's family support worker attended. The unborn baby was placed on a child protection plan under the category of neglect. Social services did not think that Ms Barnes could care for the baby in the long term, because her chaotic lifestyle was unlikely to change, and they recommended immediate fostering once the baby was born. The final decision was for the family court. That evening, Ms Barnes was very emotional but told her substance misuse worker that she would do everything possible to keep her baby.
47. On 11 September, the substance misuse worker reviewed Ms Barnes, who was very upset. She said that she was being bullied and asked to move wings. The substance misuse officer informed an officer but did not submit a security intelligence report. On 12 September, Ms Barnes told a nurse that she was low in mood because of social services' decision. However, she said that she would not harm herself because of her unborn baby. Ms Barnes also told the nurse that she was being bullied on her wing and wanted to move. The nurse told the investigator that she had telephoned wing staff, who said the matter was already being dealt with, so she did not submit an intelligence report.
48. On 15 September, the first of a series of monthly core group meetings about Ms Barnes' unborn baby took place at Low Newton. The meeting was chaired by the new social worker for Ms Barnes' unborn baby. Ms Barnes and her offender supervisor attended. Ms Barnes' other children lived with their grandparents but the social worker told her that it would not be possible for the new baby to be placed with them. Ms Barnes said that she wanted to keep the baby and move to a prison mother and baby unit. The substance misuse worker supported Ms Barnes after the meeting.
49. On 16 September, a GP saw Ms Barnes and recorded a plan to review her mood and consider a methadone reduction programme once the baby was born. On 17 September, Ms Barnes moved to B2 landing. On 22 September, the midwife

checked her. On 23 September, a GP reviewed Ms Barnes with two nurses. She said that her medication was working and the voices were not bothering her. They agreed that she would continue on olanzapine, diazepam and methadone. Ms Barnes said she was being bullied, but nobody at the meeting submitted an intelligence report to the security department. The same day, the offender supervisor referred Ms Barnes to the PIPE unit, at her request, because of her probable diagnosis of personality disorder.

50. On 27 September, Ms Barnes' parents and two children visited her. On 28 September, Ms Barnes asked to see a nurse and told her that her mood was increasingly low and she was feeling tearful. She had increasing thoughts of suicide and self-harm and said she had made plans. She said that the only thing stopping her harming herself was her pregnancy and the likelihood that a suicide attempt would worsen her position with social services. At 3.15pm, the nurse began ACCT procedures. A supervising officer instructed staff to observe Ms Barnes at least twice an hour and record two conversations with her each day. Ms Barnes said he was not happy on B Wing and wanted to move to the PIPE unit.
51. At 2.10pm on 29 September, an officer assessed Ms Barnes, who said she felt lonely and like an outcast. She was anxious that she was going to be separated from her baby and said she was somebody who always thought the worst was going to happen. Ms Barnes said she was ashamed that her family had to visit her in prison and she had felt depressed after their most recent visit. She said that she had no friends on B wing and stayed in her cell. She said that she had been feeling low and depressed for some time and that thoughts of harming herself came into her head throughout the day. She was eating for the baby's sake, but had suffered from anorexia in the past. The officer noted Ms Barnes' history of self-harm and recorded in the triggers section of the ACCT document: 'Pregnant and has been told baby will be removed immediately after birth'.
52. At 3.10pm, a supervising officer held the first ACCT case review with an officer and Ms Barnes. A nurse had briefed the supervising officer beforehand, but no healthcare staff attended. She told him that Ms Barnes was having increased thoughts of suicide and self-harm and that ACCT procedures should continue because of her 'current stressors and pregnancy'. The review assessed her risk of suicide and self-harm as low, but kept the frequency of observations at two each hour. The supervising officer recorded Ms Barnes' low mood as the only issue in the ACCT care map. The action required was to raise her mood and the mental health team and the wing staff were given responsibility for this.
53. On 1 October, Ms Barnes moved to a single cell on the ground floor of the PIPE unit. A nurse reviewed Ms Barnes and noted she was a little better but her mood was up and down, and she had ongoing, fleeting thoughts of self-harm. On 2 October, the substance misuse worker saw Ms Barnes who did not look well and said she felt like she was suffering opiate withdrawal symptoms. The worker advised that this was normal near the end of a pregnancy and the GP might need to increase her methadone dose. On 3 October, a nurse saw Ms Barnes and on 4 October, Ms Barnes spent time in the sensory room, which is specially designed to provide a calm environment.

54. On 6 October, a supervising officer and an officer from the safer custody team held the second ACCT case review. Ms Barnes said she was feeling low but did not intend to harm herself because of the baby. She said she was finding it a bit easier to cope, thanks to the support of PIPE staff and the mental health team. Observations remained at twice an hour and the review assessed Ms Barnes' risk of suicide or self-harm as low.
55. Later that morning, the social worker chaired a second core group meeting at Low Newton, attended by Ms Barnes, the offender supervisor, the midwife, two nurses, and a worker from the drug and alcohol recovery team. Before the meeting, Ms Barnes had told the social worker, 'If the baby goes, I'll go too'. The social worker alerted a nurse to this comment. Ms Barnes was upset and tearful but her mood settled. The social worker restated the social services' recommendation that the baby should be fostered outside the family. Both nurses offered Ms Barnes support afterwards. The same day, a GP increased Ms Barnes' prescription of methadone to 50ml daily to prevent her and the baby experiencing withdrawal symptoms. That evening, Ms Barnes told the offender supervisor that she would seek legal advice and intended to prove social services wrong.
56. On 7 October, Ms Barnes went to hospital for an ultrasound scan. The same day, she attended a mental health awareness session on the PIPE unit.
57. On 8 October, during a PIPE session, staff noted that Ms Barnes' mood was low. At midday, wing staff went to lock up Ms Barnes and found that she had burnt her left forearm with a cigarette lighter. A nurse treated the burn. At 2.00pm, a supervising officer and one of the PIPE officers held the third ACCT case review. Ms Barnes said she found her job in the kitchen difficult because of her pregnancy and the supervising officer arranged for Ms Barnes to be reallocated to education classes. Ms Barnes said she regretted self-harming as she recognised it might affect her chances of keeping her baby. Despite her act of self-harm, the case review assessed her risk as low and maintained the same frequency of observations.
58. On 13 October, Ms Barnes told nurses at the treatment hatch that she was in debt 'up to her eyeballs' and the nurses submitted this information to the security department in an intelligence report. That day, Ms Barnes told the midwife that her head was in bits, she was not sleeping well, her mood was low, and her appetite was poor.
59. Also on 13 October, a supervising officer held the fourth ACCT case review with an officer from the PIPE unit and an officer from the safer custody team. A nurse made a telephone contribution beforehand on behalf of a colleague. Ms Barnes said she had burnt herself to relieve her stress about the likely removal of her unborn baby, as the pain distracted her from her painful thoughts. The review assessed her risk of suicide and self-harm as low and maintained the same twice hourly frequency of observations. The supervising officer added a second issue to the care map that Ms Barnes got bored. PIPE staff were given responsibility for organising activities to relieve her boredom. The supervising officer noted that this action had been completed that day.

60. On 15 October, staff noted that Ms Barnes left the dining hall as soon as another prisoner went in. They suspected that Ms Barnes owed this woman a debt for drugs. The staff submitted this information to the security department in an intelligence report.
61. The same day, a nurse saw Ms Barnes, who said she was still upset about the planned removal of her child and wanted to fight the decision. She told the nurse that her recent self-harm had been aimed at achieving some release from her anxiety, but it had not helped. She was anxious that she did not have enough occupation to distract herself and said she still had fleeting thoughts of self-harm but had no plans to act on them. Ms Barnes' ACCT document was not with her as it should have been, so the nurse telephoned the wing staff and asked them to make an entry for her about her meeting with Ms Barnes. Ms Barnes attended a PIPE unit session that day. She said she had settled on the unit, and enjoyed having things to do and the extra support from residents and staff.
62. On 18 October, Ms Barnes' parents and children visited her. The same day, she had a fight in the dining hall with two prisoners. Ms Barnes told staff that she was being bullied over a tobacco debt she owed to one of them. She was scared to go to the education department and the dining hall. The staff submitted an intelligence report about the incident. Ms Barnes would not provide a statement and was worried about possible repercussions, so staff took no further action.
63. On 19 October, Ms Barnes attended a PIPE unit session. The same day, social services issued a letter formally notifying her of their intention to apply for her unborn baby to be taken into care. On 20 October, a supervising officer and two officers held the fifth ACCT case review. Ms Barnes said that she was feeling a little better, after a visit from her family. She said that she was settled on the PIPE unit and had no issues there. The staff continued to assess her risk as low and reduced the frequency of observations to once an hour at all times. However, the front cover of the ACCT document still indicated that observations should be twice an hour. That day, a nurse noted in Ms Barnes' medical record that she was concerned that the ACCT case review had taken place without anyone from the mental health team attending. That day, Ms Barnes told the midwife that she was feeling very low about the likely removal of her unborn baby.
64. On 26 October, Ms Barnes told a nurse that she had fleeting thoughts of self-harm but no specific plan. They discussed her baby going into care and she was tearful. On 27 October, a supervising officer held the sixth ACCT case review with two officers. A nurse from the mental health team made a telephone contribution using a colleague's notes. Ms Barnes' mood was low and her body language was closed. She said that she had problems with another prisoner on the unit. The case review noted that these issues would hopefully be resolved but did not record any more details or how this would be achieved. Ms Barnes said that her mood was up and down and she was having fleeting thoughts of self-harm. She was looking forward to another visit from her family. The review assessed her risk as low and maintained the hourly frequency of observations, as well as a minimum of two conversations each day. This was correctly recorded on the ACCT front cover.

65. On 29 October, Ms Barnes became worried that her baby was not moving. Staff took her to hospital, where she was monitored and told that her baby was in good health. When she got back to the prison a nurse checked her. Ms Barnes said she was exhausted by her ongoing negative thoughts but had no active plans for suicide or self-harm.
66. On 3 November, a supervising officer and two officers held the seventh ACCT case review. Ms Barnes said that her mood had not changed since the last case review but she had no new thoughts of self-harm or suicide. She was still concerned about what would happen to her baby. The review assessed her risk as low and maintained the same level of observations and conversations. The midwife saw Ms Barnes the same day and she was still in a low mood. On 4 November, Ms Barnes was taken to hospital for a scan and later had a visit from her solicitor.
67. On 5 November, Ms Barnes handed a four page note to PIPE staff, in which she said she was unhappy about her perceived lack of progress on the unit, although she acknowledged that she had only been there a month. She said that she did not fit in there and was considering going back to a main prison wing. At the end of the note, she wrote that she had had enough and would rather just not 'be here' anymore.
68. On 6 November, Ms Barnes attended a pre-proceedings meeting at Low Newton about the future of her unborn child with the social worker, her solicitor and PIPE staff. On 7 November, Ms Barnes told a nurse that she still hoped for a move to a mother and baby unit and had ongoing fleeting thoughts of self-harm.
69. On 10 November, a supervising officer and an officer held the eighth ACCT case review. A nurse gave a telephone contribution beforehand on behalf of a colleague. Ms Barnes said she felt fed up and was still having fleeting thoughts of self-harm. The review assessed her risk as low and maintained hourly observations but asked staff to record three conversations each day, in the morning, afternoon and evening. The supervising officer noted on the care map that Ms Barnes was still waiting to see the psychiatrist. He added a third issue to the care map that Ms Barnes had pregnancy problems due to methadone and that the doctor should review her methadone prescription. A GP reviewed Ms Barnes later that day, and increased her dose of methadone to 55ml daily.
70. On 12 November, Ms Barnes had a visit from her solicitor. On 13 November, a GP saw her when she felt very unwell. Her symptoms indicated possible early labour, so staff took her to hospital, but she came back later that night, as it was a false alarm. On 15 November, Ms Barnes had a fight with another prisoner. Both women claimed to have been assaulted by the other. Ms Barnes said she had been pushed up against a wall. A nurse checked her and she was not injured. No staff witnessed the incident and an officer warned both women about their conduct. Staff submitted an intelligence report.
71. On 17 November, a supervising officer and an officer held the ninth ACCT case review. A nurse updated the supervising officer by telephone beforehand. Ms Barnes said she still had thoughts of harming herself at night. The review assessed her risk as low and reduced the frequency of checks to one in the morning, one in the afternoon and one in the evening, but hourly during the night.

Later that morning, the midwife reviewed Ms Barnes, who was having cramps and looked unwell. She said she was getting hassle from women on the unit. The midwife did not report this.

72. That evening, Ms Barnes argued with a prisoner and a different prisoner told staff that Ms Barnes was hoarding her medication so that she could take it all at once to 'get high' and potentially overdose. On 18 November, an officer submitted a 'Challenging Behaviour Incident Form' naming Ms Barnes as an alleged victim and two other women as alleged bullies. Staff believed that one of these women was taking Ms Barnes' medication. However, when they asked Ms Barnes she denied it, so they took no further action.
73. On 19 November, the social worker held a third core group meeting at Low Newton with Ms Barnes, the offender supervisor and a nurse. Wing staff noted in the ACCT record that the meeting did not go well. On 21 November, Ms Barnes received a copy of the social worker's report.
74. On 23 November, a SO, a nurse and an officer held the tenth ACCT case review. Ms Barnes described ongoing fleeting thoughts of self-harm, but said she did not plan to act on them. The staff continued to assess her risk of suicide and self-harm as low, and maintained the same frequency of observations. Ms Barnes attended a PIPE unit session that day.
75. On 24 November, an independent reviewing officer chaired a review child protection conference at Low Newton. Ms Barnes, her solicitor, the offender supervisor, the social worker and a nurse attended. Ms Barnes asked for the decision about her baby to be postponed until she was released from prison and, in the meantime, asked to move to a mother and baby unit. However, social services maintained their position that they intended to apply immediately for the child to be fostered outside the family. Ms Barnes was upset but coped well during the meeting. The nurse wrote in Ms Barnes' medical record that extra support should be put in place for Ms Barnes after the baby was born.
76. On 26 November, Ms Barnes went to hospital for a check up as she was having contractions. They were not labour contractions and she returned to the prison. On 27 November, the offender supervisor completed a birthing plan for Ms Barnes. In line with child protection arrangements, this focussed on what would happen to the baby rather than Ms Barnes' postnatal care. Ms Barnes was no longer working and was regarded as on maternity leave. The substance misuse worker checked her on 28 and 29 November. On 29 November, her parents and children visited her.
77. On 30 November, a supervising officer and an officer held the eleventh ACCT case review. The supervising officer told the investigator that she had invited a member of the mental health team but none could attend. A nurse wrote in the clinical record that she gave a telephone contribution beforehand, but there are no details of what she told the supervising officer. At the case review Ms Barnes said she felt good. She said she did not know what would happen to her baby but accepted that she could not change the outcome. She had no thoughts of suicide or self-harm. The staff assessed her risk of suicide and self-harm as low and ended ACCT monitoring. There is no record that they considered the original trigger, which referred to Ms Barnes' distress about the removal of her

baby. The first care map issue (low in mood) and the third issue (pregnancy problems due to methadone) were not formally signed as completed. The supervising officer issued Ms Barnes with an ACCT closure support plan outlining sources of further support and steps she could take to avoid self-harm. The officer said that Ms Barnes' good mood and presentation during the review were the main reason to end ACCT procedures and she had no concerns about her.

78. On 1 December, the midwife visited Ms Barnes, who decided to have an elective caesarean section. Ms Barnes said she wanted to breastfeed the new baby as this could help with the baby's withdrawal symptoms. She was aware that this might not be possible as she would have to return to prison and the baby was then likely to be fostered. A nurse reviewed Ms Barnes the same day and Ms Barnes became tearful when she talked about her family. On 2 December, Ms Barnes went to hospital for an antenatal clinic appointment.
79. On 7 December, a supervising officer saw Ms Barnes in her cell for a post-closure ACCT review. He said she seemed fine and they shared a joke. She said that she had no current thoughts of suicide or self-harm. The post-closure form asks if the problems which prompted ACCT procedures had been resolved. In this section, the supervising officer wrote that Ms Barnes still had ongoing problems about her pregnancy and social services. The supervising officer did not restart ACCT procedures but, because these concerns had not been resolved, he recorded that there should be a further post-closure ACCT review on 14 December, as a precaution to monitor any changes in Ms Barnes' mood. He told the investigator that he had asked a worker from the safer custody team to book this review. She said he did not ask her and there is no record that a second post-closure review was arranged.
80. That evening, Ms Barnes was taken to hospital as it was suspected that she had gone into early labour, but it was a false alarm and she returned to the prison at 10.30pm.
81. On 8 December, Ms Barnes attended a PIPE session run by a higher assistant psychologist. The psychologist noted that she engaged well and contributed to the group. The same day, the offender supervisor spoke to her about her birthing plan. On 9 December, Ms Barnes was taken to hospital for an appointment and an elective caesarean section was scheduled for 11 December. The offender supervisor told the social worker of the plan and said that additional escorts to hospital for Ms Barnes to breastfeed would not be possible once she was discharged after the birth.

Friday 11 December

82. At 6.30am on Friday 11 December, Ms Barnes was taken to hospital for her elective caesarean section. Two women officers escorted her and used an escort chain on the journey to hospital and removed it as soon as Ms Barnes arrived on the ward. (An escort chain is a long chain with a handcuff at each end, one attached to the prisoner and the other to an officer.) One of the officers noted that Ms Barnes was nervous but excited. She said she wanted to bond with and feed the baby because she had suffered from depression after a previous caesarean section when the baby had been taken away from her

immediately. The baby was delivered at 1.30pm. One officer was present and the other waited outside. The baby was taken to the special care baby unit because of methadone withdrawal and jaundice. Ms Barnes had a room nearby.

83. That afternoon, a family court judge granted the local authority an interim care order giving them shared parental responsibility for Ms Barnes' baby. This meant that any contact that Ms Barnes had with her baby had to be planned in consultation with the social worker. The judge set another family court hearing for Monday 14 December.
84. That evening, two new officers took over the escort. They took Ms Barnes to see and hold her baby. At some stage that day, Ms Barnes gave the escort officers the names of five prisoners she alleged were using illicit drugs on the PIPE unit. The names were submitted to the security department in an intelligence report.

Saturday 12 December

85. The next morning, Saturday 12 December, the escort officers noted that Ms Barnes was feeling much better. At midday, she went to the special care baby unit and held her baby. At 2.00pm, Ms Barnes' solicitor visited her to tell her about the interim care order. Later, a man claiming to be her partner tried to telephone the ward but she was not allowed to speak to him. The social worker also telephoned, but Ms Barnes would not speak to her. At 6.30pm, Ms Barnes saw her baby again. That evening, Ms Barnes was taken to the special care baby unit to express milk and stayed to watch the baby being fed.

Sunday 13 December

86. On the morning of Sunday 13 December, Ms Barnes visited the special care baby unit in the morning and early afternoon to nurse her baby. One of the escort officers said that Ms Barnes mostly expressed milk but also tried to breastfeed. Her mood was quite positive and she showed off photos of her baby that the midwives had taken. She talked hopefully about a move to a mother and baby unit, but also acknowledged that the baby might have to be fostered. She seemed to think that she would eventually get her baby back and they would not lose contact altogether.
87. The orderly officer in charge of the prison that weekend visited the hospital and hospital staff advised her that Ms Barnes was ready to be discharged. The orderly officer spoke to the duty governor and they agreed with the hospital staff that Ms Barnes would be discharged and that the prison would arrange regular daily escorts to the hospital, morning, and afternoon where possible, for Ms Barnes to feed her baby. The orderly officer told the investigator that the plan was for this arrangement to continue until the family court directed otherwise. The social worker and offender supervisor were not consulted or informed.
88. At 4.00pm, Ms Barnes was taken back to prison, restrained by an escort chain. A healthcare support worker (HCA) checked Ms Barnes in her cell when she got back. She was tired and sore. The HCA offered to admit her to the healthcare unit for observation, but she signed a disclaimer and chose to stay on the PIPE unit to be with her friends there. Ms Barnes had no appointments scheduled with the GP, substance misuse team, or mental health team.

Monday 14 December

89. At 9.10am on Monday 14 December, Ms Barnes was taken to hospital restrained by an escort chain. The officers removed the escort chain while she was checked by a nurse, fed the baby and expressed milk. At 11.00am, she was taken back to the prison. At the hospital's request, a nurse checked Ms Barnes' blood pressure when she returned, which was within the normal range. The nurse thought that Ms Barnes seemed happy and proud of her baby. She was in a positive mood and talked about how she was going to turn her life around.
90. One of the community midwives planned to visit Ms Barnes in prison on Monday but the prison had not informed the midwifery team that Ms Barnes was being taken to hospital. She telephoned the prison and arranged for a midwife to check her at hospital instead.
91. At 2.55pm, Ms Barnes was taken back to the hospital. After the escort chain was removed, she cuddled and breastfed her baby and expressed milk. A midwife checked Ms Barnes at the hospital and she got back to the prison at 6.10pm. That evening, Ms Barnes spoke to her friend. The friend told the investigator that Ms Barnes had said she could not do it anymore and could not carry on like this, but would not do anything stupid as she had too much to lose.
92. During the day, the Head of Healthcare discussed Ms Barnes with two of the nurses. They did not think that it was in Ms Barnes' best interests for her to be breastfeeding and bonding with her child, as the baby would inevitably be taken into foster care. They did not think that the hospital visits were particularly helpful in the long term.
93. That day, there was another hearing at the family court. Social services wanted the potential foster parent to visit the hospital to nurture the baby. The judge sanctioned a foster-to-adopt placement through the local authority but did not make a final decision. Ms Barnes' solicitor still advocated a placement in a mother and baby unit, so the judge asked for more information. A further hearing was set for Friday 18 December. The social worker was due to visit Low Newton on 17 December to hold the next child protection core group meeting.

Tuesday 15 December

94. On Tuesday 15 December, staff asked the duty governor if they needed to arrange an escort to take Ms Barnes to hospital. He did not know Ms Barnes and did not know what arrangements had been made or what she had already been told. At a morning meeting with managers he asked whether an escort needed to be arranged and the Head of Healthcare and the Head of the Offender Management Unit said that there was no obligation to take Ms Barnes to hospital. He cancelled further hospital escorts for the time being. Nobody informed Ms Barnes about this decision or spoke to the other agencies involved, such as the hospital and social services.
95. That morning, Ms Barnes attended a session on the PIPE unit run by the higher assistant psychologist. She made two cards to take to her baby in hospital that day. The psychologist noted that she was bright in mood, engaged well and seemed to enjoy herself. The substance misuse worker did not know that Ms

Barnes had been discharged from hospital and told the investigator that she saw her by chance on the unit. Ms Barnes said she was 'over the moon' and showed her a photograph of the baby. She told her that she was going to fight for her baby.

96. As the prison had told the midwifery team that Ms Barnes was going to be making daily visits to the hospital, an officer had arranged a midwife to see her at the hospital on Tuesday. Because the prison had cancelled her hospital visits, Ms Barnes did not see a midwife that day.
97. During the late morning, Ms Barnes told an officer that she was unhappy that no one had come to take her to the hospital. She was distressed and did not know what was happening. The officer telephoned the orderly officer, who had just arrived at midday. She went to speak to the duty governor. He told her that there had been a multidisciplinary decision that the escorts would be stopped with immediate effect. She did not know at the time whether the court or social services had been involved in this decision. She telephoned the officer and told her that Ms Barnes' escort had been cancelled. The officer said that Ms Barnes was upset and a manager would need to explain the decision to her. The officer went to the PIPE unit and told Ms Barnes that her escort had been cancelled and that somebody would come to see her to explain why. Ms Barnes was confused about what was happening, as she was supposed to be expressing milk for the baby and did not have a breast pump in prison.
98. The orderly officer asked a SO, who was working in the Offender Management Unit, to tell Ms Barnes that she would not be taken to hospital to feed her baby anymore. The orderly officer was not sure whether she had also said that this was because the baby was being taken into foster care. She did not know that Ms Barnes had recently been monitored as at risk of suicide and self-harm, but warned the supervising officer that Ms Barnes was likely to be upset by the news. (Her offender supervisor, who might have been expected to speak to Ms Barnes about this decision, had just finished his shift.)
99. At about 1.00pm, the supervising officer went to the PIPE unit with a trained family liaison officer to see Ms Barnes. She had first checked that Ms Barnes was not subject to ACCT procedures. She told Ms Barnes that she would not be going back out to hospital, but that social services would arrange for her to see her baby again before care proceedings were completed. She recalled that Ms Barnes had said very little in response. The officer sat with her on the bed. Tears were running down her face and she was quietly upset.
100. Ms Barnes asked to see her friend, and the supervising officer brought her. She said that Ms Barnes asked no questions and just wanted to be left alone with her friend. The friend said that Ms Barnes had been devastated, even though she had always known that her baby would be taken away. She said that Ms Barnes said she wished that someone had told her the day before, so she could have spent more time with her baby at the hospital.
101. The supervising officer wrote in the wing observation book about Ms Barnes, 'Notified that baby is being taken into foster care. Very tearful. Wing staff to offer support'. She told the unit manager what had happened. She did not think that

Ms Barnes needed to be monitored under ACCT procedures because she had not voiced any thoughts of suicide or self-harm in response to the news.

102. The night patrol officer on the PIPE unit that week said that he had spoken to Ms Barnes for a couple of minutes on Monday and Tuesday evening, because of her circumstances. On Tuesday evening, he asked her if she was OK, and she had replied angrily, 'What do you think?' He said that she then apologised and explained that she had had a 'shit day'. During the medication round at 10.00pm, the night manager said that Ms Barnes had asked a nurse for more pain relief, but the nurse had told her that there was no more prescribed.

Wednesday 16 December

103. On Wednesday 16 December, an officer telephoned the healthcare team and asked somebody to check Ms Barnes because of the confusion about the arrangements the day before. She said that the nurse she spoke to seemed to think that Ms Barnes was still being taken to hospital each day. At about 10.00am, a nurse telephoned the community midwifery team to ask for a breast pump and for a midwife to check Ms Barnes, as she had not seen a midwife since Monday. One of the community midwives took the call. She had not met Ms Barnes before but agreed to visit the prison.
104. The midwife arrived at 11.00am and saw Ms Barnes in the healthcare centre. Ms Barnes said that she was OK, just a bit sore. The midwife said that although she appeared jovial, she also said that she was upset about no longer being taken to see her baby. Her caesarean section scar seemed to be healing well. The midwife put on a fresh dressing, gave her a breast pump and had no concerns about Ms Barnes' mood. Because the prison had not warned the midwifery team that the planned escorts had been cancelled the day before, Ms Barnes' postnatal notes were still at the hospital and the midwife could not consult them.
105. That morning, to distract herself, Ms Barnes asked to attend a creative session making Christmas crackers in the PIPE unit. She seemed to enjoy the session and spoke about her visits to see her baby being stopped. The higher assistant psychologist who ran the session, told the investigator that, considering Ms Barnes' circumstances, she seemed to be handling the decision surprisingly well. She did not seem to dwell on it and was not tearful or upset.
106. A supervising officer went to see Ms Barnes in her cell later that day to check how she was coping. She said she was frustrated that she was no longer able to visit her baby. He noticed that other prisoners were being very supportive. He thought that Ms Barnes seemed to be bearing up very well and did not consider that she was at risk of suicide.
107. At about 2.00pm, there was a graduation ceremony in the PIPE unit. The room was full and very hot. Ms Barnes felt faint and had to be guided down to the floor. Somebody pressed the general alarm and the staff placed her in the recovery position. A nurse responded to the general alarm and treated Ms Barnes. She thought that she had collapsed because of her recent caesarean operation and the very hot room. She noticed that the extra food, which Ms Barnes was supposed to receive when breastfeeding had been cancelled, and

- asked the kitchens to restart this. Ms Barnes was taken back to her cell in a wheelchair.
108. Later, after having some fluids and food, Ms Barnes recovered and went to the wing office and apologised to an officer for causing a scene. At about 4.30pm, the nurse checked Ms Barnes. She was chatting with other women at the time and said that she felt much better. She asked how many bottles she would need for the milk she was expressing.
 109. Ms Barnes' friend told the investigator that Ms Barnes had seemed all right on Wednesday and had not mentioned any suicidal thoughts. She had been pleased that her milk was being taken to the hospital. She thought Ms Barnes was still quite depressed, but this was not unusual for her.
 110. At about 7.15pm, a nurse checked Ms Barnes. Her colour was normal and she said she felt better. She told Ms Barnes that she would get paracetamol for pain relief at the 10.00pm medication round. She had seen Ms Barnes three times that day and said she had no concerns about her. When another nurse arrived for the night shift, her colleague handed over and asked her to give Ms Barnes paracetamol at 10.00pm. Officer A arrived for his night duty at about 7.45pm. The day officer handed over to him and told him that Ms Barnes had fainted earlier that day. The night officer said that when he saw Ms Barnes during a routine roll count, he told her to let him know if she needed anything, including the Samaritans or Listeners service.
 111. At 10.05pm, the night manager escorted a nurse to the PIPE unit, to give out medication. The night manager unlocked Ms Barnes' cell for about 90 seconds. She was on the bed watching television at the time and the nurse went in and gave her paracetamol. Ms Barnes gave the nurse a bottle of expressed milk.
 112. The night manager said that Ms Barnes was agitated and abrupt. She asked for more pain relief but the nurse told her that nothing else had been prescribed and she would need to speak to someone from the healthcare team the next day if she needed more. She said that Ms Barnes was obviously not happy with this but accepted it. Officer A said that Ms Barnes was frustrated and grumpy. The nurse told the investigator that Ms Barnes was not depressed or tearful and she had no concerns about her. The nurse and the night manager then left the unit.
 113. At 10.27pm, Officer A heard a crashing noise from Ms Barnes' cell. He looked through the observation panel in her door and she was sitting on the bed with the television on. He asked her what was wrong and she said, 'What the fuck do you think? I want my fucking meds'. He repeated that she would need to talk to someone from the healthcare team about this, the next day. He said that Ms Barnes had said, 'I don't want to wait until tomorrow. Fuck tomorrow. I want my meds now.' She then told him to fuck off. He encouraged her to settle down.
 114. At 11.01pm, Officer A decided to check Ms Barnes again. He looked through the observation panel but could not see her; the television was on and the shower room door was open. He said he shouted to her two or three times but got no reply. He came back very shortly afterwards, but still got no response from her. At 11.02pm, he went to the wing office, telephoned the night manager and asked her to come to the unit. He said that Ms Barnes had been banging around in her

cell but had now gone quiet and he could not see her or get her to respond to him.

115. Shortly after 11.04pm, Officer A went back to Ms Barnes' cell and continued to try to get a response from her. On her way to the unit, the night manager collected a nurse from the healthcare centre and radioed the assistant night manager to attend.
116. At 11.07pm, the night manager and nurse arrived at Ms Barnes' cell. The night manager looked through the observation panel and called Ms Barnes' name but got no response. She unlocked the cell, went in but at first could not see Ms Barnes. She then saw Ms Barnes hanging from the shower rail by her dressing gown cord, which was tied very tightly. She cut through the cord and Ms Barnes fell backwards into the shower cubicle, hitting her head. She then cut the rest of the cord from around her neck. The nurse checked Ms Barnes, who had no pulse and was not breathing.
117. The nurse asked for an emergency bag and a defibrillator and Officer A went upstairs to collect them. However, the defibrillator was stored separately and he brought back only the emergency response bag. The nurse asked him to go back for the defibrillator, which took about another 30 seconds.
118. It was difficult to treat Ms Barnes where she lay, so the night manager pulled her out of the shower cubicle onto the floor. The night manager asked the nurse about an ambulance and the nurse said they should call one immediately. At 11.11pm, the night manager radioed the control room and asked for a blue light ambulance, stating 'suspended ligature' and 'prisoner unconscious'. At 11.12pm, control room staff called an ambulance. She radioed again, stating that the prisoner was Ms Barnes and a blue light was needed and it was a code red emergency. Control room staff asked if she meant code blue (the correct code for such circumstances) and she said that the prisoner was suspended from a ligature and not breathing.
119. The nurse began chest compressions and the night manager gave oxygen using a bag-valve-mask. Officer A took over chest compressions while the nurse attached the defibrillator, which could not find a shockable rhythm and advised them to continue resuscitation. An ambulance arrived outside the prison at 11.19pm and three paramedics reached the cell at 11.24pm. They took over emergency treatment but at 11.48pm, recorded that Ms Barnes had died.

Contact with Ms Barnes' family

120. The duty governor went to the prison and, after consulting the Governor, asked the police to visit Ms Barnes' parents and inform them of her death. Her parents lived 70 miles from the prison and there were adverse weather conditions and serious flooding at the time. Because of the flooding, the police waited until the morning and notified Ms Barnes' parents at 8.30am. At 9.30am, she telephoned Ms Barnes' father to offer condolences and give him more information about what had happened. Later that morning, an officer was appointed as the prison's family liaison officer.
121. On 29 December, the officer went to see Ms Barnes' parents and returned her property. Ms Barnes' funeral was held on 31 December. The officer and the Head of Safer Custody represented the prison. The prison contributed to funeral costs, in line with Prison Service policy.

Support for prisoners and staff

122. Immediately after Ms Barnes died, the night manager sent the nurse and two officers to the healthcare centre with the three paramedics, where they had a cup of tea to help recover from the shock. The women in the PIPE unit were upset and shouting, so she went around the cells to calm them down. She asked an officer to review any prisoners in the PIPE unit who had been assessed as at risk of suicide and self-harm, in case they had been adversely affected by Ms Barnes' death.
123. At 7.00am on 17 December, the duty governor and Governor debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support. At 7.20am on 17 December, the duty governor asked staff to review all prisoners assessed as at risk of suicide and self-harm. At 7.30am, an officer and a prison chaplain gathered all of the PIPE prisoners together and broke the news of Ms Barnes' death. The women were allowed to spend the rest of the day unlocked on the unit, sitting in the association room and supporting each other. The prison posted notices informing other prisoners of Ms Barnes' death, and offering support.

Post-mortem report

124. After Ms Barnes died, some prisoners suggested that she had taken drugs shortly before her death. None of the staff we interviewed who saw Ms Barnes on 16 December, considered that she had been under the influence of drugs and toxicology tests commissioned by the coroner found no evidence of alcohol or illicit drug use before she died. The post-mortem examination identified the cause of death as pressure on the neck due to hanging.

Findings

Clinical care

125. The National Institute for Health and Care Excellence (NICE) set out their clinical guidelines for antenatal and postnatal mental health in December 2014. These require the healthcare provider to develop an integrated care plan for mothers with a mental health problem, both during pregnancy and the postnatal period. This plan should set out the proposed treatment and the responsibilities of all healthcare professionals and name a care coordinator. The coordinator should ensure that everyone involved in the mother's care is aware of their responsibilities, that information is shared effectively between agencies and with the woman, that mental health is part of all care plans and that treatment is timely. After childbirth, healthcare staff should review the woman's mental health medication once she is medically stable.
126. There has also been recent research into the deaths of new mothers which emphasises the level of risk suicide faced by women such as Ms Barnes after giving birth. Mother and Babies: Reducing Risks through Audits and Confidential Enquiries across the UK (MBRRACE-UK) are part of the National Perinatal Epidemiology Unit at the University of Oxford. They published a report in December 2015 entitled 'Saving lives, improving mothers' care'. The study found that women are at a higher risk of experiencing a severe mental illness in the early days after birth than at any other time in their lives. MBRRACE described this as a period of immense vulnerability. A pre-existing mental health problem can increase the risk. The MBRRACE study identified that many of the mothers who died came from vulnerable populations with multiple complex social, medical and mental health factors. Those who took their own lives were on average 29 years old and most were white and British. Most had already had one or two other children. Almost a quarter were known to social services. Some took their own lives shortly after decisions were made about taking their child into care. While there had been a necessary focus on the baby's welfare, MBRRACE identified a simultaneous 'under-recognition' of the vulnerability of these mothers.
127. Ms Barnes had complex needs and a number of risk factors:
- She was in prison for the first time.
 - She had a history of impulsive self-harming behaviour.
 - She had a history of serious mental health problems which increased the risk of postnatal mental illness.
 - She had a very significant history of substance misuse.
 - Social services had just been granted an interim care order for her other children and she had been warned that her new baby was likely to be placed into foster care and adopted.
128. There were several times when staff either noted that Ms Barnes would need postnatal care or flagged up the risk during the postnatal period but nothing was done:

- On 16 September, a GP noted in the clinical record that a GP should review Ms Barnes' mood and consider methadone reduction after she gave birth.
 - On 6 October, Ms Barnes told the social worker, 'If the baby goes, I'll go too'. The social worker passed this information to a nurse.
 - On 24 November, the nurse recorded in Ms Barnes' medical record that she would need extra support after her baby was born.
129. For a long time at Low Newton, Ms Barnes had good protective factors in place. She had regular contact with a GP, a midwife, a worker from the substance misuse team, a nurse from the mental health team and her offender supervisor and the mother and baby unit liaison officer. She was monitored under ACCT procedures during the autumn and moved to the supportive environment of the PIPE unit. Her pregnancy itself was a protective factor. At ACCT case reviews, she said that she would not self-harm for the sake of her unborn child and also to show social services that she could cope.
130. However, after Ms Barnes was discharged from hospital, after giving birth, few of these protective factors were in place. There are a number of reasons, but the root cause was the failure to plan for the postnatal period. We found:
- No single person had with overall responsibility for coordinating Ms Barnes' care.
 - There was no multidisciplinary meeting to discuss Ms Barnes' care and support during her pregnancy and the postnatal period.
 - No one drew up a multidisciplinary care plan involving the midwife, mental health nurse, substance misuse keyworker, GP and her offender supervisor.
 - There was no contingency planning for staff absence in the mental health team to cover the mental health nurse's absence.
 - There was no joint working between the community midwives and the mental health team.
 - No one drew up a separation plan to support Ms Barnes while the local authority took her baby into care.
 - There was little recognition of the particular issues for women in Low Newton's safer custody policy, with no mention of pregnancy, separation from children or postnatal depression.
131. The lack of multidisciplinary planning meant that decisions about Ms Barnes' postnatal care were taken on an ad hoc basis. There was poor communication within the prison and with Ms Barnes and little coordination between the different agencies. We found that:
- No one from the prison told the social worker that ACCT procedures had ended, and social services assumed that Ms Barnes was being supported inside prison during family court proceedings.
 - None of the professionals who had been closely involved with Ms Barnes were booked to see her after she returned from hospital. She had no postnatal review of her medication and no mental health assessment.

- Although offender supervisor originally told the social worker that Ms Barnes would not be taken back to the hospital after the birth, prison managers then made a well-intentioned, ad hoc decision to allow Ms Barnes to visit and feed her baby. They told Ms Barnes that she would be taken to the hospital twice daily. Social services should have been advised of this decision because they had an interim care order.
- Social services were planning for the potential foster mother to start visiting the baby in hospital. Without communication between the prison and social services, Ms Barnes' ad hoc prison escorts risked her meeting the foster mother at the hospital.
- The hospital visits were cancelled without warning when managers made another ad hoc decision without consulting social services, the hospital, the midwives, or Ms Barnes.
- It was several hours before anyone told Ms Barnes. A supervising officer did not know the full circumstances surrounding the decision, did not know Ms Barnes, and was not certain about the message. We do not think it was made clear to Ms Barnes that this was a decision by prison managers and not part of a final decision by the family court.
- No one identified that the decision increased Ms Barnes' risk of suicide and self-harm.
- Nobody from the prison told the midwives that they had stopped the hospital visits so Ms Barnes missed her daily midwife appointment at the hospital on Tuesday 15 December. This also meant that Ms Barnes' postnatal notes were left at the hospital and not available when a midwife checked her at the prison on 16 December.
- The prison did not obtain a breast pump for Ms Barnes until three days after she returned to prison.
- Ms Barnes' extra food allowance to help her milk production had been cancelled and had to be restarted.

132. The clinical reviewer reviewed Ms Barnes' clinical care and found some individual examples of good practice. The mental health care Ms Barnes received was of an acceptable standard and substance misuse services, the GP service, primary care and the midwifery service were all, individually, delivered to a good standard. However, he found that each team worked in isolation and there was not enough communication between them. Ms Barnes' care was fragmented, there was a lack of joined-up working among the healthcare teams and there was no multidisciplinary care plan coordinated by a named individual. He therefore found that overall Ms Barnes' care was not equivalent to that she would have received in the community. Her care was not in line with NICE guidelines. We make 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.

133. When MBRRACE looked at the deaths of mothers with a history of mental health problems, they found poor communication between primary care and maternity services in about a quarter of cases. We identified several basic failures by those caring for Ms Barnes to share information. The visiting community midwives could not see all of the entries in her clinical notes because they did not have complete access to the SystemOne medical record system used in prisons. GPs did not attend the daily morning meeting for healthcare managers, the only regular forum for information sharing by the different healthcare teams. This meant that they missed important updates about patients.
134. The PIPE unit is jointly funded by the National Offender Management Service and NHS England. The PIPE psychologists work for Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV). They record their contacts with prisoners in an electronic document that is separate from both the prison record and the clinical record. They do not have any access to SystemOne and make only brief entries on prison records to note their contact with women. The mental health team at Low Newton also work for TEWV, but on a separate contract commissioned by NHS England. They record all their contacts in the SystemOne medical record. Even though both teams have the same employer, the mental health nurse could not read what the psychologists were writing about how Ms Barnes was coping day-to-day in the PIPE unit. It is important that all teams responsible for a woman's mental wellbeing have access to all relevant information. We make the following recommendation:

The Head of Healthcare should ensure that:

- **PIPE psychologists record their contact with women in the SystemOne medical record.**
- **Community midwives are able to view the complete SystemOne medical record and make relevant entries in the record.**
- **GPs attend the morning meeting where possible.**

Managing the risk of suicide and self-harm

135. PSI 64/2011 expects ACCT case reviews to be multidisciplinary where possible and there is a mandatory requirement that healthcare staff must attend the first case review. Although the mental health nurse attended the first case review when Ms Barnes was initially subject to ACCT procedures in June, no member of healthcare staff attended her first case review at the start of the second period of ACCT monitoring, on 29 September. As Ms Barnes had mental health problems, substance misuse issues and was pregnant, this is particularly concerning. Advice from the healthcare staff should guide the case manager at case reviews. A mental health nurse attended only one of the 11 later case reviews. We are

particularly concerned about the lack of involvement of mental health nurses in the ACCT process, as we had already identified this as an issue in the investigation into the death of a woman at Low Newton in December 2013.

136. The one case review attended by the mental health nurse was the only one which was multidisciplinary. ACCT case managers did not invite Ms Barnes' midwife, substance misuse worker or offender supervisor to any case reviews. This meant that they missed potentially valuable contributions to inform their decision making.
137. We are particularly concerned that, despite Ms Barnes' imminent due date and longstanding mental health and substance misuse problems, staff decided to end ACCT monitoring on 30 November, without the participation of any of the key professionals who had worked closely with Ms Barnes. A trigger for suicide and self-harm had been recorded as, 'Pregnant and has been told baby will be removed immediately after birth'. When the ACCT procedures ended, Ms Barnes was 26 days from her due date, there had been a meeting with social services six days earlier and all of the professionals involved in her care were well aware that the baby was likely to be removed and fostered. There is no record that this trigger was considered.
138. We are also concerned about risk assessments at ACCT case reviews. When ACCT procedures began in September, the first case review on 29 September assessed Ms Barnes' risk as low, even though she had just reported having continuing thoughts of self-harm and said she had plans to harm herself. PSI 64/2011 says that the level of risk must be reviewed at each case review, taking into account the frequency, method and lethality of any new incidents of self-harm. Ms Barnes harmed herself by burning her arm on 8 October, but the case review shortly afterwards continued to assess her risk as low. This was contrary to guidance in the ACCT document itself, which says that a new incident of self-harm should prompt a raised risk assessment.
139. Ms Barnes was regarded as a low risk of suicide and self-harm at all eleven case reviews in the autumn and had also been assessed as low risk throughout the first period of ACCT monitoring in the summer. This does not suggest that case managers fully reassessed her risk at each case review and did not fully consider her different risk factors and changing circumstances. In our preliminary findings into the death of a woman with serious mental health problems at Low Newton in January 2016, we have also identified a problem of consistent low risk assessments at ACCT case reviews.
140. Case managers did not use the ACCT care map effectively. Of five different case managers who chaired case reviews in the autumn, only one supervising officer recorded any issues or updated the care map. PSI 64/2011 states that each care map action must be tailored to meet the individual needs of the prisoner, designed to reduce the risk and assigned to a named member of staff, as well as being detailed and timebound. Not all issues were reflected in the care map and actions were unclear and unspecific. For example, the action to address an issue of low mood was to raise her mood. The action to deal with boredom was to relieve her boredom, rather than specifying any particular practical action.

141. Instructions for ACCT procedures emphasise the importance of continuity of case management. Ms Barnes had five different case managers in two months, which we do not consider provided appropriate continuity of care. The supervising officer, who chaired the final case review, had not attended any of the preceding ten case reviews, had not seen Ms Barnes since the summer and was not up to date with her current issues. She said that she has never received any refresher ACCT case manager training, despite chairing case reviews for about ten years.
142. PSI 64/2011 recommends that prisoners at risk of suicide and self-harm are managed under an enhanced case review process in a number of circumstances. Management by an enhanced review team is not mandatory, but it includes more specialists and a higher level of operational management. With the complexity of Ms Barnes' situation, we believe it would have been appropriate to consider an enhanced case review approach. A more high-level approach from an enhanced case review team should have resulted in more multidisciplinary involvement and a more coherent and coordinated approach to managing Ms Barnes' situation.
143. At an ACCT post-closure review on 7 December, a supervising officer noted that Ms Barnes had ongoing problems due to being pregnant and the situation with the baby and social services. The supervising officer knew that the trigger for suicide and self-harm had previously been identified as Ms Barnes' distress about the removal of her baby and, because he was concerned, he planned a further post-closure review on 14 December, which never happened. We consider that it would have been prudent for him to restart the ACCT procedures, in the light of his concerns. We make the following recommendation:

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

- **Holding multi-disciplinary reviews with continuity of case management and involving all staff who can contribute to the care of a prisoner at risk, with healthcare staff attending at least all first case reviews.**
- **Case reviews taking full account of all known risk factors, including reviewing the recorded triggers when determining a prisoner's risk of suicide or self-harm and fully recording the reasons for decisions.**
- **Using the enhanced case review process when appropriate.**
- **Setting effective care map objectives, which are specific and meaningful, identifying who is responsible for completing them and reviewing them at each case review.**
- **Holding post-closure interviews in line with PSI 64/2011 and reopening ACCTs when there is an indication of continuing or additional risk.**

Bullying

144. Low Newton's violence reduction policy was published in April 2015. In the section entitled 'Managing incidents of bullying behaviour', it states that the safer custody team will investigate an allegation of bullying within 72 hours. Ms

Barnes told healthcare staff about alleged bullying on 11, 12 and 23 September and 17 November. The healthcare staff did not submit intelligence reports to assist information gathering but on at least of these occasions they informed prison staff. There is no evidence that this was followed up. Prison officers witnessed incidents of potential bullying on 15 and 18 October and again on 15 and 17 November. Despite all of these reported incidents, we only found one example of an officer completing a 'Challenging behaviour incident form'. While there was nothing to indicate that bullying was a factor in Ms Barnes' death, such behaviour can increase the risk of vulnerable prisoners identified as at risk of suicide or self-harm. We found no evidence of any investigations into any of the allegations and suggestions that Ms Barnes might have been bullied or any discussion at ACCT case reviews. We make the following recommendation:

The Governor should ensure that all incidents of alleged bullying are investigated in line with the local violence reduction policy.

Emergency response

145. After Officer A could not get a response from Ms Barnes shortly after 11.00pm on 16 December, he telephoned the night manager to report his concerns and then waited at the cell. He did not know there was any immediate risk to life at the time, so we consider that this was a reasonable course of action.
146. In June 2015, Low Newton issued a notice to staff about emergency medical codes. In line with Prison Service Instruction 03/2013, the notice requires that staff should radio a medical emergency code blue in circumstances such as when a prisoner is found hanging and control room staff should call an ambulance immediately. However, it took four minutes after the night manager went into the cell, before she radioed for an ambulance. No one else radioed an emergency while she was cutting the ligature and moving Ms Barnes to a suitable position to begin resuscitation. Although she initially referred to a code red, rather than code blue, we do not consider this added to the delay.
147. The nurse asked Officer A to bring the emergency equipment stored in the PIPE unit. Although this did not take long, he had to make two trips because he brought only an emergency response bag and forgot the defibrillator, which is stored in the same area but separately from the main bag. We make the following recommendation:

The Governor should ensure that all staff are aware of PSI 03/2013 and local guidance and understand their responsibilities during medical emergencies, including that staff use the appropriate code to communicate a medical emergency immediately and that staff bring all relevant emergency equipment promptly to the scene.

**Prisons &
Probation**

Ombudsman
Independent Investigations