

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Ms Lynsey Bartley, a prisoner at HMP New Hall on 19 March 2016

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

Our Vision

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

Our Values

We are:

Impartial: *we do not take sides*

Respectful: *we are considerate and courteous*

Inclusive: *we value diversity*

Dedicated: *we are determined and focused*

Fair: *we are honest and act with integrity*



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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 Lynsey Bartley was found hanged in her cell at HMP New Hall on 19 March 2016. Ms Bartley was 29 years old. I offer my condolences to Ms Bartley's family and friends.

This is a critical report and, although Ms Bartley was clearly a needy and challenging prisoner, many aspects of her care fell short of what I would expect. Ms Bartley did not receive the proper assessments or care from the mental health team. She was put onto the violence reduction regime but, as a consequence of this, as well as her disabilities and health needs, her progression through the system was not properly reviewed or assessed. In essence, she was kept in segregated conditions for nearly eight weeks without co-ordination and oversight of her care by a senior manager.

Ms Bartley spent nearly all day, every day, alone in her cell. She wrote in her violence reduction workbook that she wished to die, but this was not read or acted on by staff. A decision was made a week before her death to return her to the beginning of the process, meaning she would face at least another four weeks mainly alone in her cell. Ms Bartley wrote several appeals to managers and the Independent Monitoring Board but without success. She asked the mental health team for help, saying she thought about ending her life but, other than a routine referral, no action was taken.

Ms Bartley's death was, in my view, both predictable and preventable.

This is one of two recent deaths at New Hall, in which my investigations have found serious shortcomings in the care provided. The prison has many strengths, but much more work is needed to ensure that some of the very troubled women it has to care for are kept safe – even from themselves.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman

January 2017

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Summary

Events

1. On 15 January 2016, Ms Lynsey Bartley was convicted of theft and sentenced to 32 weeks imprisonment. She was sent to HMP New Hall, where she was well known to staff, having served earlier sentences there. The main difference on this occasion was that Ms Bartley had had part of her hip removed following an infection and was awaiting hip replacement surgery. She was advised to use crutches, to live in one of the prison's disabled-access cells, not to work and be given help with showering. The GP prescribed strong pain relief. There is evidence to suggest that on different occasions Ms Bartley sought to conceal illicit drugs and that she offered to trade some of her medication with other prisoners in exchange for tobacco. She therefore became the subject of two adjudications and was punished with cellular confinement, loss of earnings, loss of television, loss of association, and loss of tobacco, with all meals to be eaten in her cell. During the early part of her sentence, Ms Bartley was also managed under the suicide and self-harm support (ACCT) procedures.
2. On 22 January, an officer found a letter which Ms Bartley had written to another prisoner, asking her to order items from the canteen on her behalf. This behaviour is regarded as a form of bullying and, following an investigation, Ms Bartley was placed onto stage two of the violence reduction programme. This made her subject to a very restricted regime. In essence, she was unable to leave her cell other than to collect her medication or take a shower.
3. Ms Bartley's progress through the violence reduction programme was reviewed each week but the correct forms were not used, the reviews were not multi-disciplinary and the workbook Ms Bartley completed was not assessed. She struggled to progress through the programme and had to repeat some weeks more than once. By 4 March she had successfully moved to week four - the last week - and things seemed to have turned a corner. However, at the next review it was decided she would have to repeat week four then, on 12 March, a custodial manager decided to move her back to week one - restarting the whole process - because Ms Bartley had been abusive towards other prisoners.
4. Ms Bartley appealed this decision and made several wing applications during the following week asking for a wing move, to go to education classes or be given work to complete in her cell. She also asked to see her personal officer, a named individual who was one of a team of six officers, to whom Ms Bartley had been assigned. Although he was required to make entries in her case notes at least monthly, he made no entries of a personal officer nature in relation to Ms Bartley during this sentence. Although New Hall was unable to provide us with copies of all of these applications, in some of them, Ms Bartley recorded that she "felt like ending it all". Little was done in response to her applications and her appeal against the violence reduction decision was not resolved before her death.
5. Ms Bartley often gave staff information about illicit activities that prisoners on the wing were engaged in, but the other prisoners were aware of her doing this and she was called a 'grass'. Ms Bartley would shout out of her cell at other

prisoners if they aggravated her. She felt that staff only saw her reaction and never seemed to witness what other prisoners were doing or saying to her.

6. The mental health team also received several applications from Ms Bartley. In her last two applications, Ms Bartley wrote about suicide and self-harm and asked for help. Although these applications were discussed at the weekly team meetings, no one from the mental health team went to see Ms Bartley to assess her needs and to establish whether she was at risk of suicide or self-harm.
7. On Friday 18 March several staff spoke to Ms Bartley and she was offered a wing move - something she had been requesting for some time. However, in the event, Ms Bartley decided not to move. Around tea time a prisoner brought Ms Bartley her meal and reported that she was obviously upset. Again, Ms Bartley talked about "ending it all". In the evening, after prisoners were locked up, Ms Bartley told a friend that she was thinking of taking her own life. Her friend made her promise not to, and because Ms Bartley gave her promise, the friend did not alert staff. At 5.04am, Ms Bartley was found hanged in her cell by the night patrol during the morning roll count. It was clear Ms Bartley had been dead for some time because rigor mortis had already set in. Nurses began cardiopulmonary resuscitation (CPR) and used a defibrillator, continuing until paramedics arrived and pronounced Miss Bartley dead.

Findings

Physical care

8. Overall, the care Ms Bartley received was of a good standard and equivalent to the care she could have expected in the community.

Mental healthcare

9. The standard of care provided by the mental health service was not equivalent. There was little involvement with other services, mental health team meetings appeared perfunctory, and decisions regarding Ms Bartley's care were sometimes made without face to face assessment. Assessments of Ms Bartley's risk of suicide and self-harm should have been made in response to her written statements that she intended to harm herself. Discussion at team meetings appears inadequate to properly assess her needs.

Concealing medication

10. We found evidence that Ms Bartley and other women in New Hall conceal their medication and sell or exchange it, either out of choice or because they are pressurised into doing so.

Applications to the mental health team

11. Several of Ms Bartley's applications were not passed to the mental health team in a timely way. We also had concerns about confidentiality as prison workers were able to read prisoner applications.

Violence Reduction

12. While the initial decision to place Ms Bartley onto the Management of Violence Strategy (VR2) was reasonable, the administration of the VR2 system was poor and Ms Bartley had few of the interventions suggested in the policy document to help her move forward. We saw no evidence that any of the weekly case review meetings were multi-disciplinary, we saw no completed forms for Ms Bartley's reviews and do not think Ms Bartley's workbook was reviewed weekly. There is no form on which to appeal VR2 decisions. There is little evidence that Ms Bartley was managed in line with local policy. It was excessive that Ms Bartley's adjudication punishment of a long period of cellular confinement ran simultaneously with her VR2 regime restrictions.

Management of Ms Bartley's ACCT documents

13. Ms Bartley had three ACCTs opened and closed during her sentence in New Hall. We think that the decision to close her first ACCT was premature and when her third ACCT was opened, the case review should have included a review of her violence reduction status and the adjudication punishment. ACCT reviews were insufficiently multidisciplinary: most were attended by someone from the mental health team, but there was rarely anyone else present besides the case manager and Ms Bartley. Entries in the ongoing record were often purely observational whereas the system should operate as a support system.

Assessing the risk of suicide and self-harm

15. While completing the violence reduction workbooks each week, Ms Bartley wrote down many disturbing thoughts and feelings. No one conducting the reviews explored her feelings with her. Ms Bartley made many applications asking for help, for a wing move, to do education and speak to her personal officer. Despite reading these applications and discussing them in team meetings, no one from the mental health staff did anything to assess or support Ms Bartley or open a further ACCT. Some of the applications do not have dates or reference numbers on them, few were followed up before her death and it is unclear whether there are target timescales or a system in place to check the progress of applications.
16. While most staff did not think Ms Bartley was the 'type' of prisoner to commit suicide, we think several listed risk factors became more prominent in the last week of her life and that she was at heightened risk. Staff who saw Ms Bartley the day before her death thought she seemed well and had no concerns about suicide or self-harm, although they did not ask her directly how she was feeling.

Co-ordination of Ms Bartley's regime and care

17. There was no co-ordinated or properly considered approach to Ms Bartley's care, particularly the cumulative impact of her isolation and the restrictive VR2 regime. Ms Bartley should have been managed as a complex case because of her physical health restrictions, mental health needs and violence reduction status. A senior manager should have had overall responsibility to co-ordinate her care and treatment in prison, overseeing the VR2 system, ACCT process, mental health care, physical health care needs, education opportunities, and personal

officer input. The manager should have chaired a weekly meeting, bringing together the various departments providing care to Ms Bartley.

Personal Officer Scheme

18. Ms Bartley's personal officer made no relevant entries in her case notes, as is required, and made just one entry as part of the VR2 daily entries which staff must make when someone is on the violence reduction regime. Ms Bartley's wing application to see her personal officer on 18 March was not acted on before her death. There is little to suggest any of the officers on Willow tried to get to know Ms Bartley, to talk to her or support her in moving off the VR2 regime.

Adjudication on 15 February

19. It is not clear from the adjudication what rule or regulation she supposedly disobeyed, whether she was charged with the correct offence or that it was properly explored during the adjudication.

Resuscitation

20. Prison and medical staff attempted to resuscitate Ms Bartley when it was clear that she had been dead for some time and the clinical reviewer found that in this instance attempts at resuscitation were futile.

Emergency response

21. PSI 03/2013 (Medical Response Codes) requires governors to have a medical emergency response code protocol and states that all prison staff must understand the protocol and their responsibilities during medical emergencies. At the end of our opening visit, we told New Hall that their instruction was not in line with national protocol and advised them to issue a new local instruction as soon as possible. They did so, and on 30 March 2016, published notice 081/16. We do not therefore make a further recommendation about this.

Recommendations

- The Head of Healthcare should review the mental health assessment process to ensure that accurate, timely assessments of need take place and that these are discussed by the team in a meaningful way to ensure that prisoners are offered mental health interventions that meet their needs.
- The Governor and Head of Healthcare should review and improve systems to prevent prisoners diverting their medication.
- The Governor and Heads of Healthcare for Spectrum Healthcare CIC and Nottinghamshire Healthcare NHS Trust should review the healthcare application administration process and ensure that applications are processed in a timely and confidential manner.
- The Governor should review the violence reduction policy and how it is implemented, particularly in relation to prisoners with known vulnerabilities. An appeal process should be introduced.

- The Governor should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national instructions, including:
 - a multi-disciplinary approach for all case reviews with continuity of case management where possible;
 - completing ongoing ACCT records fully and accurately, including details of conversations and interactions with prisoners. Purely observational entries should be kept to a minimum; and
 - setting ACCT caremap actions which are specific and meaningful and which are aimed at reducing prisoners' risks to themselves.

- The Governor should review the wing application system to ensure that applications have a date, log number and department or name of the recipient. There should be target timescales for responding and a system designed to follow up and ensure applications are answered.

- The Governor should review how prisoners with complex care needs are identified and managed within New Hall so that such prisoners receive a co-ordinated approach to their care and management by a senior manager.

- The Governor should ensure, in line with the personal officer protocol, that personal officers understand their responsibilities, work with prisoners on the violence reduction regime and make regular entries in prisoners' case notes.

- The Governor should advise staff of the appropriate adjudication charge to bring when they believe a prisoner has sold, or is attempting to sell, their medication or illicit drugs to other prisoners.

- The Governor should ensure that all staff receive guidance about the circumstances in which resuscitation is inappropriate.

The Investigation Process

22. The investigator issued notices to staff and prisoners at HMP New Hall informing them of the investigation and asking anyone with relevant information to contact her. No one came forward.
23. NHS England commissioned a clinical reviewer to review Ms Bartley's clinical care at the prison.
24. The investigator visited New Hall on 24 March 2016. She obtained copies of relevant extracts from Ms Bartley's prison and medical records.
25. The investigator interviewed seventeen members of staff and four prisoners at New Hall in April. The clinical reviewer was present for the interviews with medical staff. Five staff provided written answers to questions because they were unavailable for interview. The investigator spoke to a member of the Independent Monitoring Board on the telephone.
26. We informed HM Coroner for West Yorkshire Eastern District of the investigation. He gave us the results of the post-mortem examination and we have sent the coroner a copy of this report.
27. One of the Ombudsman's family liaison officers contacted Ms Bartley's mother, to explain the investigation and invite her to raise any relevant questions and concerns. She told us about her daughter's previous history of self-harm and asked whether the prison was aware of this history. She asked whether her daughter had self-harmed whilst in New Hall on this occasion, and if she was known to be depressed. If so, she asked us to consider whether the prison should have been keeping a closer watch on her daughter, and whether she should have been contacted and informed.
28. Ms Bartley's family received a copy of the initial report. They provided feedback which has not led to any factual changes.

Background Information

HM Prison

28. HMP New Hall is a closed female local prison, holding around 400 remanded and sentenced women and young offenders. It can also accommodate nine mothers and 10 babies in the mother and baby unit. Primary health care services are run by Spectrum Community Health Community Interest Company (changing to Care UK in August 2016). Mental health services are provided by Nottinghamshire Healthcare NHS Foundation Trust.
29. Willow House is made up of three small units; A (non-smoking unit), B (general unit) and C (new arrivals / induction unit). B wing has a disabled-access cell which comprises two former cells knocked into one. The only other disabled-access cell in New Hall, a normal sized cell fitted with handrails, is in Holly unit, the healthcare unit.

HM Inspectorate of Prisons

30. The most recent inspection of HMP New Hall was in June 2015. Inspectors reported that the prison had improved since the last inspection and was “among the best of its type”. They judged New Hall to be fundamentally safe, with very little evidence of violence or incidents of concern. Some prisoners and staff told inspectors there was a link between low wages, debt and trading in medication or illicit drugs.
31. Inspectors felt that support for women who were vulnerable to self-harm and those with complex needs was good, although aspects of assessment, care in custody and teamwork case management processes could be improved. Mental health staff were present at most Assessment, Care in Custody and Teamwork (ACCT) case reviews, but staff from other disciplines rarely attended. Inspectors said relationships between staff and prisoners were a real strength and the caring, but challenging, approach adopted by most staff facilitated and supported much of what was good about the prison. They found the mental health provision to be excellent.

Independent Monitoring Board

32. 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 2016, the IMB reported that there had been staff reductions and a new core day for prisoners as part of a national benchmarking process across prisons. The Board said the programmes for drug and alcohol abuse were held upstairs on a wing, making it impossible for wheelchair users and others with mobility issues to access these courses.

Previous deaths at HMP New Hall

33. Ms Bartley was the first prisoner to die at New Hall since February 2014. Another prisoner took her own life just over a month after Ms Bartley. Although there were no notable similarities between the circumstances of these two deaths,

we have serious concerns about the overall co-ordination of care and management of both women.

Assessment, Care in Custody and Teamwork

34. Assessment, Care in Custody and Teamwork (ACCT) is the care planning system the Prison Service uses for supporting and monitoring prisoners assessed as at risk of suicide and 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. Levels of supervision and interactions are set according to the perceived risk of harm. There should be regular multi-disciplinary case reviews involving the prisoner. Guidance on ACCT procedures is set out in Prison Service Instruction 64/2011 (Management of prisoners at risk of harm to self, to others and from others (Safer Custody)).

Violence Reduction

35. The Management of Violence Strategy policy was issued by New Hall in May 2015. It states that any resident identified or suspected of violence, aggressive or intimidating behaviour against another resident will be challenged and a range of actions taken, based on the severity of the alleged incident. The approach taken to manage residents under this policy must be constructive and avoid the individual becoming entrenched in problem behaviour.
36. The violence reduction strategy has three stages indicating the level of concern:
- VR1: an incentives and earned privileges warning is given and the prisoner is placed under close observation for 14 days.
 - VR2: the prisoner is downgraded to basic regime for 28 days. Whilst on basic regime they must complete a violence reduction booklet in conjunction with their offender supervisor and personal officer. Each of the four modules lasts for seven days and there is a weekly review. The unit manager is responsible for ensuring that daily comments are made in the NOMIS case notes when someone is on the VR2 regime. There are case review sheets for day 7, day 14, day 21 and day 28 and space to provide a written summary of the review. The period on VR2 can be extended for another specified period of up to 28 days if there is little or no improvement. The unit governor or duty governor must approve this option.
 - VR3: where a prisoner persists in violent behaviour she will be placed on the Sycamore Unit under Good Order or Discipline arrangements. She will be required to work with her offender supervisor and personal officer to address her behaviour and a governor will review her progress on a weekly basis.

Key Events

37. On 15 January 2016, Ms Lynsey Bartley was convicted of theft at Magistrates' Court and sentenced to 16 weeks imprisonment. A suspended sentence imposed in July 2015 was also activated, meaning that in total, Ms Bartley's sentence amounted to 32 weeks. Ms Bartley arrived at HMP New Hall at 7.15pm. She had been in New Hall before and was quite well known to staff, who described her as a lively, talkative person. She had a history of self-harm and several ACCTs had been opened on her behalf in the past. The form that accompanies prisoners from court (Person Escort Record) highlighted drug use, mental health issues, physical health issues and that Ms Bartley had cut her arms in 2014. Reception staff noted her history and that she suffered with depression but Ms Bartley said she did not feel like self-harming at that time and no ACCT was opened. Ms Bartley was due to be released on 5 May 2016.

Medical history

38. Ms Bartley had been in a car accident in 2003 that left her with chronic pain in her back, seizures and some facial disfigurement. This adversely impacted her mental health and she was diagnosed with depression and anxiety issues soon afterwards. Ms Bartley misused drugs and told staff she took crack cocaine, heroin, M-Cat (mephedrone) and benzodiazepines. Ms Bartley injected drugs and had caught Hepatitis C (a blood born viral infection affecting the liver) as a result.
39. In September 2015, a consultant informed Ms Bartley's GP that she had both epileptic and non-epileptic type seizures. Ms Bartley was prescribed pregabalin (a drug used for nerve pain, but which also has an anti-epilepsy affect) and clonazepam (an anti-epilepsy drug). Ms Bartley developed a subcutaneous abscess which led to a bacterial infection in her left hip and she was admitted to hospital where the head of her thigh bone was removed. Ms Bartley required the insertion of an artificial hip joint and subsequently needed help washing and dressing. She used crutches to move around.

Medical assessments at New Hall

40. Ms Bartley's initial health screen during reception at New Hall was with a nurse. She knew Ms Bartley from previous sentences and, although the issues with her hip were new, said Ms Bartley was in reasonable spirits, did not present with any overt mental health issues and engaged well in the reception process. Due to her physical health issues, it was decided that Ms Bartley should be in a single cell. New Hall has two disabled-access cells – one double sized cell on Willow House and one normal sized cell with a wider door and grab handles in Holly House (the healthcare unit).
41. A prison GP saw Ms Bartley on 15 January. She knew Ms Bartley from previous sentences and saw a dramatic change in her medical presentation because of the issues with her hip. Ms Bartley told her she was not taking heroin, methadone or alcohol, but occasionally smoked crack cocaine. She felt Ms Bartley needed assistance with activities of daily living. She prescribed longtec (a morphine-based pain killer - changed on 16 January to oxycodone, a different brand of the same drug), naproxen (an anti-inflammatory pain killer), doxycycline

(an antibiotic), omeprazole (for gastric reflux), clonazepam (for epilepsy), pregabalin (for epilepsy), sertraline (an anti-depressant) and a one-off dose of methadone (a heroin substitute, but used in this instance as an additional source of pain relief). None of the medication was given in possession (i.e. kept in cell) and this meant Ms Bartley collected her medication daily and taking it in front of a nurse.

42. On Saturday 16 January, Ms Bartley was seen by a nurse for a secondary health screen and a referral was made to Turning Point (which provides a drug and alcohol recovery service). Physiotherapy assessments were completed. Recommendations were for Ms Bartley not to share a cell as space was needed to allow her to remain mobile. She was not to attend gym, work or education. She was to mobilise with elbow crutches, to be supervised when showering, to use a raised toilet seat and to follow standard hip precautions (such as not swivel when turning). Ms Bartley was also to be offered assistance to wash and dress, avoid walking long distances or sitting for lengthy periods. A Zimmer frame could be used in her cell if needed.
43. Nursing staff established a care plan to support Ms Bartley's physical care needs, including allowing her sufficient time to dress and undress, providing support with showering, but promoting independence where possible. The clinical reviewer said there were regular entries in Ms Bartley's medical record that describe the ongoing care received from nursing staff. A nurse said support was offered on a daily basis and that, although sometimes Ms Bartley refused it, she was mostly happy to accept. The equalities officer made an assessment of Ms Bartley's needs. She specified that, although Ms Bartley was not to work, she would look into whether education activities could be provided in her room.
44. Ms Bartley made a self-referral application to the mental health team on 18 January, in which she said she had post-traumatic stress disorder, cognitive behaviour problems, depression and anxiety. The primary care team leader received this on 21 January and viewed it as a routine referral, meaning Ms Bartley would be seen within five working days.
45. On 19 January, a prison GP met Ms Bartley and afterwards wrote a letter to the finance department requesting an orthopaedic mattress because of her ongoing hip problems. An email dated 15 March, from the finance department, asked whether the mattress was still needed. We do not think the order was placed until this date, meaning Ms Bartley did not receive it before her death.
46. On 21 January, Ms Bartley was suspected of having concealed something and staff told her she would be subject to a full body search. Ms Bartley refused to be searched and force was used in order to enable the search to take place. (We have reviewed the use of force and think it was done reasonably and carefully, with nursing staff present to advise on issues that might affect Ms Bartley's hip.) A pot of liquid was found secreted inside her underwear. Ms Bartley told a Supervising Officer that it was pregabalin and that she had bought it from another prisoner. Ms Bartley was charged with two offences against prison rules.
47. An officer was named as Ms Bartley's named personal officer. New Hall's personal officer policy states that prisoners have a team of six officers assigned to them; one named officer is designated as lead. He knew her quite well from

earlier sentences and described Ms Bartley as usually very talkative. He said that if ever Ms Bartley was harassed by other residents she would “give it back tenfold”. Personal officers are required to make entries at least once a month about prisoners assigned to them. The officer said he did not always work on B wing but, when he did he usually spoke to Ms Bartley. He did not, however, make any entries of a personal officer nature in Ms Bartley’s case notes during this sentence.

Investigation and ACCT procedures

48. On 22 January, an officer found a note Ms Bartley had written to another prisoner, asking her to order tobacco for her. She was concerned that Ms Bartley was bullying this prisoner. Later that evening, an officer issued Ms Bartley with a warning because she was heard shouting out of her door at other prisoners on the wing, calling them liars. Ms Bartley disagreed that she had been bullying people. During the night, a prisoner alleged Ms Bartley was shouting out of her window offering to sell pregabalin.
49. At 1.50pm on 23 January, an ACCT was opened because Ms Bartley told a member of staff she felt like self-harming. A Supervising Officer (SO) spoke to Ms Bartley and decided that she should be seen by staff twice an hour until the first case review.
50. The SO made an entry in Ms Bartley’s case notes on 23 January that she had carried out an investigation into the alleged bullying and interviewed staff. She found that Ms Bartley had pressurised another prisoner to order canteen items such as deodorant, crisps and chocolate and asked her to acquire things from other prisoners. This is regarded as a form of bullying and the Head of Residence was informed. He agreed Ms Bartley could be put onto VR2 - stage two of the violence reduction programme.
51. Because an ACCT was open, the decision to place Ms Bartley on VR2 had to be checked by the safer custody department. It could not therefore begin until Monday 25 January. An ACCT assessor spoke to Ms Bartley on Sunday 24 January and she told him she was struggling on her own in the disabled-access cell and wanted to share with a friend. Ms Bartley said she felt like cutting herself. He listed the key issues as her lack of mobility, her being restricted to the disabled-access cell on her own and thoughts of self-harm.
52. At the first ACCT case review at 1.40pm on 24 January, no one from the mental health team was present. (It is a requirement for someone from healthcare to attend the first review but the mental health team do not work over the weekend.) Because of this, a SO decided to keep the observation level at two per hour. Ms Bartley told the review she felt lonely and wanted to move out of the disabled-access cell in order to share. Because no one from healthcare was at the meeting, Ms Bartley’s occupation of a disabled-access cell could not be reviewed. The SO set the next review for two days later and recorded that someone from the mental health team ought to attend. Ms Bartley’s risk was assessed as low. The caremap was completed and two issues were listed – Ms Bartley’s location and issues on the wing about bullying.

53. After the review, the SO spoke to a nurse and reported that the physiotherapist felt Ms Bartley should live in the disabled-access cell as she was not able to live in a shared cell with bunk beds. The SO asked staff to keep an eye on Ms Bartley because of her allegation that others on the wing were bullying her. An officer made an entry in the case notes that Ms Bartley was deliberately aggravating other prisoners, asking for sugar and coffee and shouting about their claims that she was a bully.

Violence Reduction strategy

54. The decision whether to place someone on Violence Reduction 1 (VR1) or VR2 is taken after the initial investigation is complete. Where there is sufficient circumstantial evidence to suggest the possibility of violent behaviour, the suspected perpetrator is placed on VR1. If there is firm evidence of violence or written intelligence strongly suggesting the resident is involved in violent behaviour, the person is placed on VR2. Ms Bartley was placed on VR2.
55. The stages within VR2 are:
- i. Week one: the prisoner is on the basic level regime, does not go to work, has no association, no television, eats meals in her cell and exercises separately.
 - ii. Week two: the prisoner is on the same as week one, but regains the ability to go to work and exercise.
 - iii. Week three: the prisoner is on the same as week two, but regains her television and can dine out of her cell.
 - iv. Week four: the prisoner is on the same as week three, but regains full association
 - v. Week five: the prisoner is removed from VR2 and progresses to VR1.
 - vi. Prisoners can be made to repeat a week if they have not made enough progress through their workbook or have received any further negative comments or bullying related issues have been raised.

Violence Reduction Week 1 - Monday 25 January 2016 (due to end 1 February) No work, no association, no television, eats meals in cell and exercise separately.

56. On 25 January Ms Bartley cut her arms with a blade from a disposable razor. The cut was stitched up and an ACCT case review was held at 2.40pm because of the self-harm. A Supervising Officer carried out the review and only he and Ms Bartley were present. He wrote that Ms Bartley had self-harmed because of being put on VR2. She was upset and said she had given information to staff about other prisoners using drugs but she was being punished for it. The SO decided to keep her on two observations per hour and to hold another case review the following day.
57. Attempts were made to conduct a mental health triage assessment on 22 and 25 January, however Ms Bartley was being seen by other healthcare staff for physical health issues at those times. A third attempt was made in the afternoon of 25 January but Ms Bartley said she was in too much pain to be seen. She told

the primary care team leader she would submit a further application to the mental health team if she wanted to be seen in the future.

58. At the ACCT case review on 26 January the meeting discussed issues around Ms Bartley's physical health needs with a nurse, and it was decided that she should remain in the disabled-access cell. Ms Bartley said she had cut herself because of the bullying but was scared at the amount of blood loss and had no further thoughts of suicide or self-harm. A nurse from the mental health team, noted in SystemOne, an electronic medical case management system, that Ms Bartley asked for a mental health assessment. A SO suggested Ms Bartley read books (as her VR2 restrictions meant she did not have a television or any association). It was agreed that the ACCT would be closed and a mental health triage assessment conducted the following day. The SO felt all the issues in the caremap had been addressed.
59. At 4.30pm, Ms Bartley telephoned her mother. Her mother refused to speak to her and said the family no longer wanted anything to do with Ms Bartley.
60. A nurse went to see Ms Bartley the next day but Ms Bartley said she did not want to be seen as she was physically unwell and would refer herself if she wanted support from the mental health team. This was discussed at the mental health team meeting that day and Ms Bartley was removed from the team's caseload.
61. The same day, at 6.00pm, Ms Bartley self-harmed by removing the stitches from her arm. She was seen by a Matron and a new ACCT was opened. Ms Bartley was observed twice each hour until her first review. At 10.15am on 28 January, Ms Bartley met an ACCT assessor. She told him she was struggling to cope with everything (having previously been raped), her son and mother rejecting contact, being on VR2 and being called a 'grass'. Ms Bartley said she felt like self-harming and wished she were dead. She said she had started to hear voices and was finding it hard to cope without television or tobacco. She wanted the GP to review her medication.
62. A SO chaired the first case review at 3.00pm and wrote a summary of the review in the ACCT document. Also present were the Matron (head of the mental health team) and Ms Bartley. The SO wrote that Ms Bartley was in a very low mood, expressing a great deal of self-pity, and refusing to take responsibility for her actions. She said the issues were similar to those raised on 26 January and Ms Bartley refused to build bridges with others. There is no mention of discussion about her feelings of suicide or self-harm. The observations were to remain at two per hour and her risk level was assessed as raised. A caremap was written with two issues; location (Ms Bartley wanted a wing move) and not having a television because of being on VR2. She was given a distraction pack (which includes colouring patterns and wordsearches) and a radio instead.
63. The Matron also wrote a summary of the ACCT review on 28 January in Ms Bartley's medical record. Ms Bartley continued to say she was not the perpetrator of bullying, spoke about thoughts of self-harm "all the time" and when asked about suicide replied, "I have told people many times, I don't want to be here, and I don't mean prison". Ms Bartley said she did not have actual plans to kill herself as she acted on impulse. The Matron thought she had no protective factors as her relationship with her mother had deteriorated.

64. After the case review Ms Bartley went to another resident's cell and was found there by an officer, who told her she was on VR2 and should not be associating with other prisoners. A short while later the officer said she could hear Ms Bartley shouting to the women in that cell, asking whether they smoked.
65. Ms Bartley gave staff a written note dated 28 January. In this note she recorded names of other prisoners and times when things were said to her. Ms Bartley said that at 5.30pm she was asleep when someone kicked her door. Fifteen minutes later she said a pregnant girl kept opening and shutting her flap and saying that the prison officers had been rude about her. Ms Bartley said she could hear some residents talking about her and calling her a 'grass'. There is no case note entry or reference to the note in the ACCT record.
66. An officer made a case note entry at 6.18pm that Ms Bartley had been heard shouting to other prisoners to get away from her door. He said no prisoners were seen at her door around that time although the wing was generally quite noisy.
67. On 29 January a custodial manager spoke to Ms Bartley at 10.30am to say her mother had contacted the prison and asked to have her telephone number removed from the list Ms Bartley was allowed to call. Ms Bartley gave staff a written note dated 29 January, in which she named other prisoners and times when things were being said to her. Over the morning, Ms Bartley described several instances of prisoners talking about her outside her cell, making threats and kicking her door. Ms Bartley wrote that she was upset and exhausted and fed up that nothing was being done to investigate her complaints.
68. The entries in the ongoing record of the ACCT for 29, 30 and 31 January are only observational (eg. Ms Bartley given canteen, lying on bed eating, lying on bed reading). None of the entries describe more in-depth engagement with staff or any attempt by staff to converse.
69. Ms Bartley wrote another (undated) statement, describing it as the eighth she had written. (We have not seen all of the earlier ones). In it she named several prisoners who were trying to acquire heroin. Ms Bartley said she told an officer but that nothing happened. She said some prisoners had been abusive outside her cell and made threats to kill her. She said she was at the lowest point in her life and would kill herself if she could do so quickly and easily. Ms Bartley asked for help, adding that she could manage the stairs, as the occupational therapists had shown her how to do so with crutches. There is no reference to the statements in her case notes, but an officer recorded on 31 January that Ms Bartley had alleged another prisoner told her she was going to 'do her in', but it was not witnessed by staff.
70. Statement number nine by Ms Bartley is undated but states a prisoner threatened to punch her once she had been removed from VR2. Ms Bartley said she wanted to get off the wing and did not feel safe. She said she wanted to kill herself and that she would do so if the situation was not resolved. There are no entries by staff in the ACCT ongoing record or case notes to indicate that anything was done around this time.
71. On 31 January, Ms Bartley told a SO that another prisoner had threatened her. Although not witnessed, staff completed an intelligence report.

72. At an adjudication on 1 February, Ms Bartley was found guilty of refusing an order to be searched and for concealing drugs. She was punished with loss of earnings, canteen, private cash, television and association.
73. A Supervising Officer reviewed the first week Ms Bartley had spent on VR2 and decided she could progress to week two. The forms that formed part of the review were not completed and it is unclear whether the SO reviewed the written work Ms Bartley had done in the VR2 booklet – module one. There is no reference to having done so in the case note entry. In module one, Ms Bartley wrote that she did not think she was a bully and was being bullied herself, giving examples of bullying behaviour. There is no date on this module, so we do not know when Ms Bartley completed it, but we assume it was around this time.

Violence Reduction Week 2 - Tuesday 2 February 2016 (due to end 8 February)

Can work and exercise with others, but no association, no television, eats meals in cell.

74. Ms Bartley progressed to week two of the VR2 regime but was unable to work because of her medical condition. This meant the only change to her circumstances was to be able to take exercise with other prisoners. There are no entries in the ACCT ongoing record to show whether she was offered or went on exercise during this period.
75. At an ACCT review at 10.30am on 2 February, Ms Bartley said she had fleeting thoughts of self-harm but had not acted on them. There were no outstanding issues on the caremap. Ms Bartley asked for some education work to complete in her cell. The SO who chaired the review said she emailed the education manager to ask if Ms Bartley could be given some education work. This should have been added to the caremap. Ms Bartley's ACCT remained open but her observations were reduced to one every two hours.
76. The next day, a recovery worker with Turning Point met Ms Bartley and completed an initial assessment of her needs. Ms Bartley said her problematic substances were heroin and crack cocaine. Ms Bartley was subsequently assigned a recovery worker.
77. On 4 February, whilst she was unlocked to do some ironing, an officer said she found Ms Bartley at the door of another prisoner offering to trade her medication. She charged Ms Bartley with an offence against prison rules, paragraph 23: "disobeys or fails to comply with any rule or regulation applying to her". After being adjourned for further investigation, the matter was heard on 15 February.
78. At lunchtime, Ms Bartley told the officer that some named residents were shouting abuse at her. The officer said she was on the landing at the time and no one had gone to her door. She saw Ms Bartley spitting through her door onto the landing but, when challenged, Ms Bartley denied doing so. Over lunch, Ms Bartley was caught swinging a line (where prisoners use long lines with something attached at the bottom to pass things between cell windows).
79. A SO said the education department replied saying that there was no funding for work for Ms Bartley to complete in her cell. However, one of the managers would look into the issue further. The SO reviewed Ms Bartley's progress through the VR2 regime on 5 February and decided to return her to week one because of the

comments from wing staff over previous days. Whilst this was not an unreasonable decision, the review forms were not completed as they should have been and there is nothing to suggest it was a multi-disciplinary decision, that Ms Bartley was involved or whether her work was reviewed.

80. In module two of her workbook, Ms Bartley wrote that she had cut her arms and tried to hang herself and was being abused and called a 'grass' by prisoners because she had provided officers with information. Ms Bartley said no one was helping her and the prisoners she named had not been drug tested. She said she wanted to move to a different wing but felt 'stuck' because of the disabled-access cell. Ms Bartley wrote that she wanted to hang herself and wished she were dead. There is no date on this module, so we do not know when Ms Bartley wrote it, but we presume it was around this time.

*Violence Reduction returned to Week 1 - Friday 5 February 2016 (due to end 12 Feb)
No work, no association, no television, eats meals in cell and takes exercise separately.*

81. Staff did not always make the daily entries about Ms Bartley's behaviour while on VR2 that they were required to make. When entries were made, they described whether staff have observed any bullying behaviour that day and Ms Bartley's compliance with the regime.
82. A custodial manager investigated Ms Bartley's allegations of 29 January about being bullied by three other prisoners. Based on her allegations these women were placed on VR1, but staff had found no hard evidence to support Ms Bartley's claims. The CM decided to continue to monitor the situation.
83. On 7 February, an officer made entries in Ms Bartley's ongoing record to say she was lying on her bed and watching television at 1.30pm, at 3.30pm and again at 7.30pm. We are puzzled by these entries because Ms Bartley should not have had a television at this time because of her VR2 and adjudication restrictions. There are no other entries between 5 and 9 February (when the ACCT was closed) to suggest Ms Bartley was watching television at any time or that she had one in her cell.
84. Ms Bartley's ACCT was closed on 9 February. A SO chaired the case review and said Ms Bartley seemed to have had a change of mind and was writing down ways in which she could improve her current situation and behaviour and progress through the VR2 system. Ms Bartley had not self-harmed since the end of January and seemingly had no intention of doing so. There were no outstanding issues on the caremap. A nurse felt Ms Bartley wanted to try to repair her relationship with her mother and appeared positive for the future. All agreed that the ACCT could be closed.
85. The next day, a recovery worker from Turning Point met Ms Bartley, but was unable to do a proper assessment because Ms Bartley was not allowed to leave her cell alone because of her VR2 restrictions. Ms Bartley asked if she could have a distraction pack and colouring pack and these were provided the following day along with some harm reduction workbooks to complete.
86. On 11 February, Ms Bartley was introduced to her offender supervisor. A custodial manager made an entry in Ms Bartley's case notes that he had

answered her complaint of 31 January about not getting out of her cell for the 30 minutes she was entitled to each day. He said he would ensure she did so while on VR2 but said Ms Bartley needed to work with staff and demonstrate the right behaviours to move off that regime.

87. On 12 February, a custodial manager reviewed VR2 and decided on the basis of positive comments from staff, Ms Bartley's satisfactory completion of her workbook and her more settled week, she could progress to week two. While this was a reasonable decision and the workbook was looked at, the review forms were not completed as they should have been and there is nothing to suggest it was a multi-disciplinary decision.

Violence Reduction progression to repeated Week 2 - Friday 12 February 2016 (due to end 19 Feb)

Can work and exercise with others, but no association, no television, eats meals in cell.

88. Over the next few days there were positive comments about Ms Bartley in the case notes. She wrote to her mother on 13 February about her forthcoming hip operation. Ms Bartley said she was sorry for what she had done and told her about the agencies she was in contact with that could help her.
89. On 15 February, Ms Bartley's adjudication for "disobeying or refusing to comply with any rule or regulation" was heard by the Head of Security and Intelligence. She was found guilty and given a punishment of 14 days cellular confinement, 28 days stoppage of earnings at 75%, 28 days loss of television, association, tobacco and all meals to be eaten in her cell. These punishments would last until 13 March. The impact was to impose on Ms Bartley cellular confinement for 28 days (because she was not deemed fit to work anyway) and her only time out of cell would be to attend daily exercise periods and shower.
90. The recovery worker from Turning Point, visited Ms Bartley to try and do an assessment of her needs but she had pain in her hip from walking to and from her adjudication.
91. On 15 February, Ms Bartley made an application to the mental health team which was received by them two days later. A nurse conducted a triage assessment and said Ms Bartley did not have any increased risk of suicide "evident or expressed" at the time they met. He recorded Ms Bartley as kempt and interacting in a conversational manner. Ms Bartley said the ongoing VR2 restrictions were making her condition worse. He ticked a box on the proforma stating Ms Bartley had no involvement with substance misuse services (although Ms Bartley was being seen by Turning Point) and that she was not on medication for a mental health problem (although she was taking an anti-depressant, sertraline - information readily accessible on SystmOne). He said in his written response to questions that he based this information on Ms Bartley's answers and had not checked on SystmOne. The outcome of his assessment was to recommend Ms Bartley have sessions with Improving Access to Psychological Therapies (IAPT).
92. An officer made a VR2 entry that evening stating Ms Bartley had been making constant requests and shouting abuse at another prisoner.

93. On 16 February, Ms Bartley was given a warning by healthcare assistant because she refused to open her mouth after taking her medication to prove she had taken it properly. She suspected Ms Bartley was trying to conceal her medication. An officer recorded that Ms Bartley had been shouting to several women on the wing, asking for a cigarette. The officer commented that Ms Bartley would never progress off VR2 if she continued to behave in this way.
94. The next day, the officer made another entry about VR2 and recorded that Ms Bartley continued to ask other residents for tea bags and cigarettes. The recovery worker went to see Ms Bartley but she did not feel well enough to engage, so she said she would return the following week.
95. The Head of Security said Ms Bartley gave several pieces of information to staff about the activities of other prisoners. Ms Bartley was quite open about doing this and, as a result, other residents called her a 'grass'. He said New Hall had not asked Ms Bartley to provide information, nor was she rewarded for doing so. He asked a custodial manager to convey this to Ms Bartley and she did so on 19 February. He said Ms Bartley continued to pass notes to the prison.
96. When a SO reviewed Ms Bartley's progress on VR2 on 19 February, she decided that because of Ms Bartley shouting to others trying to persuade them to do things for her, and her poor attitude towards healthcare staff, she would not progress to week three. While this was not an unreasonable decision, the review forms were not completed as they should have been, there is nothing to suggest her workbook was reviewed, nor that it was a multi-disciplinary decision.

Violence Reduction repeat Week 2 - Friday 19 February 2016 (due to end 26 Feb)
Can work and exercise with others, but no association, no television, eats meals in cell.

97. The adjudication punishment from 15 February was still in force and Ms Bartley was on the 14 days cellular confinement (ending on 28 February).
98. On 21 February, an officer who had been working overnight, made an entry in the case notes that Ms Bartley had been a 'nuisance', asking for paracetamol and for night staff to post applications and letters for her during the day.
99. On 23 February, a SO spoke to Ms Bartley after she made an application to see her about still being on VR2. Ms Bartley told him that her mental health and anger issues made it difficult for her to move forward and that she sometimes took her frustrations out on staff. The SO advised her to appeal to a custodial manager if she felt she had grounds to be taken off VR2.
100. The recovery worker visited Ms Bartley who again declined to be seen, saying she was too tired. The recovery worker said this was the third time she had tried and they discussed a convenient time. Ms Bartley said she generally felt better in the mornings.
101. The recovery worker returned the next morning and had a one to one session with Ms Bartley, completing a comprehensive assessment, risk assessment and care plan of her drug recovery needs. Ms Bartley said she had stopped using M-Cat seven months ago but had used crack every day. She was proud that she had stopped injecting drugs. She said Ms Bartley seemed well.

102. On 24 February, the mental health triage assessment by a mental health nurse was discussed at the multi-disciplinary team meeting. They decided to refer her to Athena, a service for victims of sexual assault, with a view to counseling continuing in the community. Any support needed while Ms Bartley was in prison was to be through the "Hotel 2 function" (the duty member of the mental health team who attends the ACCT case reviews, responds to applications from those in crisis and to concerns raised by wing staff).
103. An officer wrote a case note entry at 4.00pm to say Ms Bartley was a 'drain on staff' and made applications every day about the same things. An ACCT was opened at 5.50pm after Ms Bartley made cuts to her arm. An initial assessment was carried out and it was decided that Ms Bartley would be observed twice an hour. At 7.30pm, she asked to speak to a Listener, prisoners trained by the Samaritans; two Listeners arrived and spent time talking to her in her cell.
104. The next day, an officer conducted an ACCT assessment interview and wrote that Ms Bartley had cut her arm because her mother had returned her letter without even opening it. Ms Bartley told the officer about being put back to week one of VR2 and that she could not cope with being isolated and having no television. Ms Bartley said she had previously been the victim of rape and had asked for support from a counseling service. (The officer noted that Ms Bartley was not in prison for long enough to complete a course in counseling.) Ms Bartley said she was depressed, tired, in pain and suffered with fits and falls. When asked about any current plans to end her life, Ms Bartley said she wished she was not here, but did not have it in her to harm herself.
105. The officer made a case note entry recording that Ms Bartley had 'already pushed the boundaries today' and while out for her domestic time had been asking other prisoners for sugar. The officer told her to stop this.
106. The first ACCT case review took place at 3.00pm on 25 February, chaired by a Supervising Officer and attended by the Matron and Ms Bartley. Ms Bartley said she had made the cuts to her arms because her mother had returned her letters and this had upset her. She understood why her mother had done this and talked about wanting to have a more positive relationship with her in the future. Ms Bartley talked about not being sure if she wanted to be here anymore, but said she did not have any thoughts of self-harm. The group encouraged her to use staff, the chaplains, Samaritans and Listeners as sources of support. Ms Bartley was waiting to hear from the St Giles Trust, a charity which works with ex-offenders, about help with housing after her release. She had a forthcoming GP appointment and was waiting for an appointment with Athena. These three things were written on the caremap. She continued to struggle with the VR2 regime and felt she was being treated unfairly. No structured mental health input was agreed. The ACCT observations were set at one per hour and her risk level was assessed as low.
107. An officer wrote in the case notes on 26 February that Ms Bartley was not up and dressed in time for morning medications. She said she had a long conversation with Ms Bartley and told her she was a 'drain on staff' and that she must stop shouting to other prisoners. She wrote that Ms Bartley tried to talk over her at every opportunity and had an answer to everything. This is not reflected in the

ACCT record however, which has no entries by her and no other entries about staff hearing Ms Bartley shouting to other prisoners.

108. The recovery worker emailed several agencies about support for Ms Bartley around her release date in May 2016 and contacted a worker about what support they may be able to offer. The recovery worker also emailed the Equality and Diversity Officer to discuss how Ms Bartley might be able to access the group work that Turning Point offer, given her physical limitations.
109. A SO reviewed Ms Bartley's progress on VR2 and decided that Ms Bartley could progress to week three. The review forms were not completed and there is nothing to suggest her workbook was reviewed, nor that he spoke to Ms Bartley about being on VR2. No entry was made in the ACCT ongoing record.

Violence Reduction progression to Week 3 - Friday 26 February 2016 (due to end 4 March)

Can work and exercise with others, television is returned and can eat meals in the dining room, but no association.

110. The adjudication punishment of 15 February was still in force and Ms Bartley could not associate, had no television or tobacco and could dine in cell only.
111. On 27 February, an officer made an entry in the case notes to say Ms Bartley had been given her television back and would have been allowed to dine out but that her physical mobility issues meant she would remain in cell. Ms Bartley was pleased to have her television returned. There is no entry relating to whether healthcare was asked if Ms Bartley could go to the dining area on her crutches.
112. The next day an officer wrote that Ms Bartley "continued to be a downright menace", arguing about the television remote control. Later, another officer made a case note entry to say Ms Bartley was still subject to an adjudication punishment which included loss of television. An officer made an entry about the television and that she would take it out of Ms Bartley's cell after lunch. Later entries (29 February) describe Ms Bartley watching television, so we do not think it was removed then although it might have been subsequently.
113. A chaplain spent 30 minutes with Ms Bartley on the morning of 29 February. He wrote in the ACCT that Ms Bartley was upset at having no contact with her mother and her Mother's Day cards being returned. He said she was anxious about her forthcoming surgery. She had asked for continuing support from the chaplaincy and the next day was given a bible.
114. On 1 March, an ACCT review, chaired by a supervising officer and attended by a nurse and Ms Bartley decided to close the ACCT. Ms Bartley said she had no thoughts or intentions of suicide or self-harm, but did complain about some staff. The nurse's written entry in SystmOne about the review was quite different in content and tone from the written account in the ACCT document. In her summary she said Ms Bartley presented as low in mood and lethargic. She understood why her mother was avoiding contact and felt remorseful that she had chosen drugs and men, rather than look after her son, who, she believed, disliked her as a result. Ms Bartley had said she "doesn't want to be here" but denied having a suicide plan.

115. A custodial manager spoke to Ms Bartley to encourage her to get along with staff better. He said she was keen to blame everything on others and would not consider her own behaviour. Ms Bartley's progress on VR2 was reviewed by a SO and she decided that Ms Bartley could progress to week four. The review forms were not completed and there is nothing to suggest her workbook was reviewed.
116. In module three of the workbook, Ms Bartley described how other people saw her and how she saw herself. She said she was normally a caring, cheerful, happy person but in prison, she said, people hated her and called her a 'grass'. Ms Bartley wrote that this was because she told staff where drugs were concealed. In prison Ms Bartley said she felt depressed, suicidal, scared, fed up and "wanted to end it". Ms Bartley said she took drugs using her mother's money and deeply regretted it because she loved her mother. There is no date on this module, so we do not know when Ms Bartley wrote it, but we assume it was around this time.

Violence Reduction progression to Week 4 - Friday 4 March 2016 (due to end 11 March)

Can work and exercise with others, television is returned and can eat meals in the dining room and associate with others.

117. The adjudication punishment of 15 February was still in force and Ms Bartley could not associate, had no television or tobacco and was to dine in cell only.
118. Ms Bartley made an application to the mental health team on 4 March stating: "I disagree with your decision and know I need help from mental health. I've got PTSD, depression, anxiety, panic attacks and cognitive behaviour problems. Lately I'm very angry and cutting my arms, punching doors etc".
119. Ms Bartley attended a course run by Turning Point on 8 March called Introduction to Change, which looks at individual's motivation. This course was run in a ground floor room so that Ms Bartley was able to attend on her crutches.
120. On 9 March, Ms Bartley went to chapel and spoke to a chaplain for 10 to 15 minutes. The chaplain said Ms Bartley told her about her life on the wing but did not think Ms Bartley seemed upset or anxious. The chaplain is an ACCT assessor and had no reason, from what she heard, to believe Ms Bartley had thoughts of ending her life or of self-harm. Rather, she thought Ms Bartley appeared frustrated and annoyed with staff on the wing.
121. A supervising officer visited Ms Bartley to do a post-closure review of her ACCT. He said Ms Bartley was "very jolly" and another resident had been helping to clean her room. He said there were ongoing issues with her family, but Ms Bartley was happy in herself and had been getting on better with wing staff. She was in contact with the St Giles Trust about accommodation on release. Ms Bartley said she had been accepted to do maths and English courses in education and was on the waiting list to start.
122. An officer made an entry in the wing observation book recording that another prisoner told her Ms Bartley was trading her tablets with several named prisoners. The officer told the nurses and they said they would ask the GP to prescribe liquid medication to make it more difficult for Ms Bartley to do this.

123. A nurse saw the application from Ms Bartley dated 4 March on 10 March and took it to the multi-disciplinary team meeting later that day. Their decision was that no new concerns had been raised and that, as a referral had already been made to Athena, Ms Bartley should be discharged and supported through the Hotel 2 function. We have, however, seen a contradictory email from two workers who work for Athena. They confirmed that Ms Bartley had been referred to their service on 24 February but because their service was closing on 31 March, it was decided on 9 March that Ms Bartley would be referred back to the prison's mental health department. An email confirming this was sent on 15 March. This does not seem to have been considered during the mental health team meeting.
124. On 10 March, an officer said Ms Bartley continued to ask other residents for things such as breakfast cereal.

*Violence Reduction repeat Week 4 - Friday 11 March 2016 (due to end 18 March)
Can work and exercise with others, television is returned and can eat meals in the dining room and associate with others.*

125. An officer made a case note entry on 11 March recording that another resident told her Ms Bartley was selling her medication for tobacco. When she went to Ms Bartley's cell, she found a coat belonging to this person.
126. On 11 March, Ms Bartley made nine applications, not all of which we have been given copies of. Two went to the education department, five to finance, one to 'the governor' (we do not have a copy of this) and one to Acorn House (family support workers).
127. At 11.25am on 11 March, a supervising officer reviewed Ms Bartley's progress on VR2 and decided that because there were issues regarding bullying that week, Ms Bartley could not progress and was to repeat week four. The review forms were not completed and there is nothing to suggest her workbook was reviewed. The adjudication punishment from 15 February was still in force.
128. Module four of the violence reduction booklet describes the difference between passive, aggressive and assertive behaviour. Ms Bartley wrote about her risk factors and the need to avoid 'high risk' people and thoughts. Ms Bartley wrote about having 'high risk' feelings and wanting to commit suicide because everyone hated her. She was on VR2 for no reason she wrote, had no one, had nothing, was sick of her life and said she wanted to be dead. There is no date on this module, so we do not know when Ms Bartley wrote it.
129. Ms Bartley's oxycodone tablets were stopped on 11 March and changed to liquid form because she was suspected of having tried to conceal her medication in order to sell it to others. A pharmacist noted the change from tablets to liquid on 16 March.
130. Ms Bartley made another mental health application on 11 March: "My anger is getting worse, the officers are trying to say I'm imagining girls kicking my door, calling me a grass, turning my night light on and off etc. This causes me to stay on VR2 the last week. I feel like I'm going to explode, I've smashed my pad up, screamed and balled [sic] at the girls and officers but it carries on every day and

their saying it's in my fucking head it's not. ...I'm locked up for 23 1/2 hours a day and have been for 6-7 weeks. I'm not getting time out in a morning, they just forget about me, I've had mail returned from my mum again today and not one officer would speak with me for 5 minutes so I came back in my room and sobbed was thinking about cutting my throat.... I'm scared of what's going on in my head... help me please".

131. Ms Bartley was heard shouting insults out of her cell at other prisoners. She tried to persuade prisoners to approach her door to pass items. An officer recorded on 12 March that he was on the landing the whole time and heard no one provoking Ms Bartley, although one prisoner admitted having switched her night light on. In the evening, an officer recorded in Ms Bartley's case notes that he had heard her abuse another prisoner.

*Violence Reduction return to Week 1 - Saturday 12 March 2016 (due to end 19 March)
No work, no association, no television, eats meals in cell and exercise separately.*

132. On 12 March, an officer made a case note entry stating that when Ms Bartley was unlocked for medication she collected several application forms and returned to her cell to complete them. When told she needed to go and collect her medication she continued to write the applications. When she closed her cell door Ms Bartley began shouting at her.
133. Ms Bartley made nine applications. One was a confidential application to the supervising officer on the wing. (We do not have a copy of this.) Two were complaints, one requested a wing move, one was an education request and the others were about finance issues. In the education request, Ms Bartley asked if the prison could enrol her onto a course as soon as possible because she could not cope with being alone behind her door any longer.
134. A Supervising Officer (SO) spoke to a Custodial Manager (CM) about the two new pieces of information about Ms Bartley (provided by two officers). Because these were not known to the SO at the time of his decision on 11 March that Ms Bartley should repeat week four, the CM decided they were significant enough for Ms Bartley to go back to the beginning of VR2; that is to repeat the whole VR process from week one.
135. On 13 March Ms Bartley formally appealed the VR2 decision. The Head of Residence was asked to respond by 21 March. (There had been no response by the time of Ms Bartley's death on 19 March.)
136. Ms Bartley wrote a statement to the night staff saying she was being bullied by three named prisoners over a drug debt matter. She said she was being told she had now inherited someone else's debt. She said it was not right that she had been put back to the beginning of VR2 and that she had mental health problems. Ms Bartley said she had been behind her door for eight to nine weeks and that she did not deserve the loss of television for another long period. Ms Bartley asked to move to E wing, away from the people threatening her.
137. On 14 March Ms Bartley made eight wing applications; four concerned wing moves. Applications number 1696 and 1731 concerning wing moves were sent

to a CM. The prison has not been able to provide us with a copy of 1731 but, in application 1696, Ms Bartley again wrote that it was she being bullied and had just been put back to week one of VR2. Ms Bartley suggested she move to E wing, where she had friends. Ms Bartley ended her application, "Please can you come and see me. Last thing I need to be doing is self-harming and these are making me want to end it all". The CM said he did not receive either of these applications and added that if he had, in light of the comments made, he would have opened an ACCT. He said he had spoken to Ms Bartley on several occasions and did not recall her wanting to move off Willow House.

138. One of the applications was to her personal officer, asking to talk. New Hall has not been able to provide us with a copy of this application, so we do not know what Ms Bartley wrote in it. There is nothing in the NOMIS case notes however to suggest her personal officer or anyone else spoke to Ms Bartley in a personal officer capacity that week. Ms Bartley's applications also included a 'confidential' application addressed to a Governor. We do not have a copy of that application (number 1730) and New Hall has told us there is no such Governor.
139. Ms Bartley signed several medical disclaimers to say she wanted to go to education classes against medical advice and did not want assistance to shower or dress. However, later Ms Bartley accepted a nurse's offer of help with showering and dressing. She said she did not think Ms Bartley appeared depressed or in low mood, although she was annoyed and frustrated at being on the VR2 regime.
140. On 14 March, the self-referral dated 11 March was received by the mental health team. It was dealt with by a nurse who had worked at New Hall since January 2016. This was her first experience of working in a prison and she had not worked in a mental health service before. She told us she was unsure what to do with the referral, so asked another nurse for advice. She said this nurse advised her to scan it onto SystemOne and place in a folder for discussion at the next multi-disciplinary team meeting. Both nurses were fully aware of the processes involved in acting as duty mental health nurse and had not highlighted that the form was from Ms Bartley, nor discussed the contents of the referral.
141. On 15 March, Ms Bartley made four further applications including an appeal about the VR2 decision. It is unclear from the wing application (number 1736) to whom this was sent. The 'senior officer' box was ticked but there is no name and no written response was recorded.
142. Ms Bartley also wrote an application to see the IMB, complaining about the VR2 decision and why she thought it unfair. Ms Bartley complained about not being able to go to work and named two staff she felt treated her badly. A member of the IMB visited Ms Bartley the next day and informed her that because the appeal was still pending, the IMB would not get involved at this stage.
143. A recovery worker went to see Ms Bartley but was told by an officer that she was unable to leave the wing because she had been put back onto week one of VR2. She talked briefly to Ms Bartley at her door where she said she had enjoyed last week's course and was keen to do more. They agreed to meet the following week when Ms Bartley was expected to be on a less restrictive regime.

144. On 16 March, Ms Bartley was unlocked to collect her medication but staff found her on A wing. She said she was asking someone for a pen. She made an application to the St Giles Trust about where she was going to live on release.
145. On 17 March, after evening medication distribution a prisoner told an officer that Ms Bartley had offered her medication to anyone on the wing.
146. On Friday 18 March, Ms Bartley made four further applications. Ms Bartley was seen 'swinging a line' straight after medication distribution and staff suspected she was selling her medication.
147. The same day, Ms Bartley's application to the mental health team of 11 March was discussed at the multi-disciplinary team meeting. A nurse wrote: "All concerns raised in app submitted by the recovery worker are related to her situation on the wing and her behaviour, it is appropriate that IMHT do not become involved with this as this issue is managed by discipline staff. However with Athena leaving the prison the need for trauma assessment with the recovery worker is unmet, to be referred to Step 3 IAPT for assessment - if the recovery worker uses this service to complain about her situation in the prison rather than her mental health this is to be discussed in MDT - clear boundaries will need to be maintained. Referral to improving access to psychological therapies programme".
148. Ms Bartley was informed that she had been referred to the Improving Access to Psychological Therapies (IAPT) programme.
149. A CM investigated Ms Bartley's written complaint of 13 March that went to night staff. He said no one else took action in response to her statement because they saw it as his responsibility, as safer custody manager. He said he only realised nothing had been done on Friday 18 March, but acknowledged that it should have been looked at earlier in the week. He spoke to an officer and went to see Ms Bartley. Ms Bartley said the three women she named had consistently made threatening remarks to her through her door and out of the windows. The officer said Ms Bartley had been shouting out of the windows at people and they had been answering back, but what he heard was not really bullying. The CM said now the prison was aware of the allegations, they would monitor the situation more closely. He talked to Ms Bartley about moving to Poplar House (E wing) and told her he could arrange this, suggesting that a fresh start would be beneficial. However, she told him that she no longer wanted to move and wanted to stay on Willow House because she liked the big cell she was in. Ms Bartley did not bring up the VR2 decision the CM had taken the week before and he thought she seemed generally well.
150. During the afternoon, a CM took a phone call from Ms Bartley's sister in law. Her sister in law said the family wanted somebody at the prison to speak to Ms Bartley because she was threatening the family with legal action in connection with a bag of clothing destroyed by the local council. She said they did not want Ms Bartley to contact them. She passed this on and she thought Ms Bartley accepted this. She said she also spoke to another CM and he told her he was thinking of moving Ms Bartley to Holly House (the healthcare unit) on Monday so that it would be more difficult for Ms Bartley to shout to others and sell medication.

The CM did not make an entry in Ms Bartley's case notes but told us she would have done so the following day.

151. A CM said he could not remember speaking to the other CM about Ms Bartley moving wings, but did speak to another CM briefly. He asked her advice about Holly House (of which she is in charge) and was trying to find a constructive way to help Ms Bartley. He said it was a tentative discussion, with no firm plan and he had not spoken to Ms Bartley about it.
152. A worker from the 'Together Women' project which comprises several external agencies including a prisoner advice clinic. She collected Ms Bartley from her cell to meet with another worker who gives advice on resettlement and legal matters, around 3.15pm. She remembered Ms Bartley was able to walk to the centre using crutches. Ms Bartley was angry about the way she was treated because of her disability and told her about being behind her door for several weeks and her various applications about this. She said nothing Ms Bartley said or the way she appeared gave her cause for concern. She thought Ms Bartley was in the centre for around 30 minutes.
153. A prisoner took Ms Bartley her meal about 4.45pm. She felt it was obvious that Ms Bartley had been crying and said Ms Bartley commented, "I'm so depressed, I feel like ending it". She said Ms Bartley had been fine a few days before and was looking towards her release date and making a fresh start. After giving Ms Bartley her meal, she said she told staff she felt sorry for Ms Bartley "being behind her door all the time". She did not say more than this because she did not think Ms Bartley would actually do anything to hurt herself.
154. During evening association, an officer sat on a chair outside Ms Bartley's cell. He said he knew there had been some trouble on the wing earlier and had heard Ms Bartley shouting through her door. He asked her to quieten down. He told her he was going to sit outside her door to make sure nothing happened and she was comfortable with that. When association ended, the prisoners were locked up and night staff arrived.
155. Overnight on Friday 18 March 2016, several staff were working on the three units that make up Willow House. The last roll check of the evening was carried out around 9.30pm.
156. After lock-up, Ms Bartley and another prisoner were talking to each other out of their nearby cell windows within earshot of other prisoners. Ms Bartley passed a letter to the prisoner saying she had lost everything and might as well kill herself. This was the first time she had heard Ms Bartley mention ending her life and she wrote back, begging her not to do anything. Ms Bartley promised not to do anything that night. She said she would have alerted staff if she had been concerned that Ms Bartley might actually harm herself but she believed her promise. Around 11.15pm, when the conversation ended, she said she signalled to another prisoner, who was on C wing (the induction part of Willow House) in a cell facing theirs. She encouraged her to look and see what Ms Bartley was doing. She said Ms Bartley was writing and soon after the other prisoner fell asleep.

157. The prisoner recalled that Ms Bartley had said she was being bullied and was tired of people harassing her. Ms Bartley also said she wanted forgiveness from both her mother and her son and another prisoner told her they needed time to come to terms with the situation. Ms Bartley asked: "If you're gonna hang yourself in your cell, where would you do it from?" The prisoner told her not to be silly or do anything stupid and the other prisoner agreed. The other prisoner made Ms Bartley promise not to do anything, and she did. The other prisoner asked her whether she thought she needed to go on an ACCT, but Ms Bartley said not. The prisoner thought she and the other prisoner agreed to take a shower the next morning so that they could talk then. Their conversation ended around 11.15pm. When she next looked into Ms Bartley's cell a short time later, she was writing. She did not look upset, so she went to bed. No residents alerted night staff to any concerns about Ms Bartley.
158. Around 5.00am the morning roll count and check is carried out by night staff.
159. Three officers had agreed to count Willow two (B wing) together. After counting Willow one, two officers went to Willow two, arriving a few minutes after 5.00am. Officer A was to count one side of the landing and Officer B, the other. As Officer A opened Ms Bartley's door flap he saw she was suspended from something above the side of her bed.
160. Officer A used his radio to ask for hotel one (the nurse response) to attend B wing. He did not use the term 'code blue', which indicates circumstances where a prisoner is unconscious or not breathing and where the communications room must call 999 immediately, as he should have done. The radio log records this message at 4.53am but he only reached Willow two minutes after 5.00am and the prison subsequently found that the radio clock was inaccurate. The actual time was around 5.04am. Officer B ran to fetch the nurses and Officer A went to the office just outside Willow two, a matter of steps away. He told Officer C that a code blue was being called. Both staff then went to Ms Bartley's cell, arriving just after the nurses.
161. When Officer D heard the call over the radio for hotel one, she went to Willow two. Two nurses were in the healthcare office across the corridor from Willow two when they heard the radio message. As they were about to leave, Officer B appeared and the nurses followed him to Ms Bartley's cell. When Nurse A looked through the door panel she could see Ms Bartley seated with her back to the wall and a ligature tied to the window bars. She broke her emergency cell key pouch and tried unsuccessfully to open the door. Ms Bartley's cell had two doors because it was a double sized cell, but only one door can be opened.
162. Officer D arrived, took the cell key from Nurse A, unlocked the other door and they went in. Nurse B requested an ambulance and for the defibrillator to be collected from the healthcare office. Officer A brought it within a few seconds.
163. Officer B ran to the control room nearby and told an officer to call for an ambulance. Yorkshire Ambulance Service call log records the 999 call at 5.05am. The crews were dispatched at 5.06am and arrived at New Hall at 5.16am. Both gates were opened to allow the ambulance prompt access. The crew reached Ms Bartley at 5.18am. Two response cars and an ambulance arrived.

164. Ms Bartley was kneeling on the floor by the side of her bed. She had a dressing gown cord around her neck attached to the window bars. Officer D used her fish knife to cut the ligature and, together with Nurse A, moved Ms Bartley to the floor. Both nurses said that Ms Bartley was cold to the touch and displayed clear signs of rigor mortis in her limbs. Nurse A began performing CPR. Nurse B prepared the defibrillator but as the battery was low, another machine was collected from the office in Holly House. Nurse B tried to insert an airway, but Ms Bartley's jaw was too stiff to do so. Officer C used the 'ambu bag', a manual resuscitator, to give two breaths after each round of thirty cardiopulmonary chest compressions.
165. The defibrillator was applied but no shocks were given - indicating that no heart rhythm was detected. Staff members alternated in providing CPR until paramedics arrived. The paramedics pronounced Ms Bartley dead at 5.21am.
166. Ms Bartley left a note addressed to her mother. She apologised for her past behaviour but could not face a future without the support of her mother or son.
167. A nurse she told us she had received a confidential envelope on 1 April with an application from Ms Bartley, dated 12 March. Ms Bartley wrote that she had been put back on VR2 week one and had been on it for eight or nine weeks. She said she was being abused and threatened by other prisoners and wanted the help of the mental health team to explain that her punishment was too much. It is unclear why this application did not reach the mental health team until nearly three weeks after it was written and after Ms Bartley had died.

What other prisoners told us

168. A prisoner said Ms Bartley talked a lot about her family and was upset about her mother distancing herself. She felt her mother would never forgive her. She thought Ms Bartley struggled with the bullying she had experienced at the hands of some other prisoners.
169. Another prisoner said Ms Bartley agreed to sell her medication to other people in exchange for tobacco. She described Ms Bartley as confrontational but commented that staff only seemed to see Ms Bartley's reactions and not the whole event, and said other prisoners actively sought pregabalin and morphine from Ms Bartley.
170. Another prisoner described Ms Bartley as loud, outspoken and self-destructive. She did not think Ms Bartley was bullied but felt she tried to buy friends with medication and that she was caught by staff doing so. She thought the isolation on the VR2 regime must have been very difficult for Ms Bartley as she needed people to talk to. She said that on the night she died, she heard Ms Bartley talking out of her cell window telling another prisoner, "I've had enough, I'm gonna end it". She heard the prisoner tell Ms Bartley to promise that she was not going to do anything or she would inform staff. Ms Bartley promised.

Contact with the family

171. Humberside Police told New Hall that they would break the news of Ms Bartley's death to her mother who lived 70 miles away from the prison. The acting Governor said the police advised the prison that they – rather than prison staff - should break the news because of the poor relationship between Ms Bartley and

her family. At 12.30pm, an officer contacted Ms Bartley's sister in law to ask if the family would like her and another member of staff to visit them that afternoon. This was agreed and she and two officers left New Hall at 2.00pm to make their way to the family address. When they arrived at 3.20pm, the officer offered condolences and explained she was the family liaison officer and their first point of contact. She answered the family's questions insofar as she was able. She maintained regular contact with Ms Bartley's mother and the family visited New Hall and saw Ms Bartley's cell. Ms Bartley's funeral took place on 14 April 2016. The prison contributed to the costs, in line with national policy.

Support for prisoners and staff

172. A senior manager 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.
173. The prison posted notices informing staff and prisoners of Ms Bartley's death, and offering support. Staff reviewed all prisoners assessed as at risk of suicide and self-harm, in case they had been adversely affected by Ms Bartley's death.

Post-mortem report

174. A post-mortem examination found Ms Bartley had died from hanging.
175. Toxicology tests showed that all of the prescribed drugs tested for were present. The pathologist did not think any of the drugs found during the tests were taken at levels that might have contributed to Ms Bartley's death.

Findings

Clinical care

Physical care

176. The clinical reviewer judged the care received from Spectrum Healthcare to be of a good standard and equivalent to the care that Ms Bartley would have received in the community. He felt the ongoing care for Ms Bartley's complex physical health needs was delivered in a sensitive, compassionate manner and efforts were made to ensure her pain was managed effectively.
177. We have concerns, however, about the communication between medical staff and other areas of the prison. Ms Bartley was initially advised not to work by the physiotherapists who assessed her in January. This decision was not reviewed and meant Ms Bartley was not offered a place in education, despite making many applications. As several other women attend education classes on crutches or in wheelchairs this, in itself, should not have been a barrier to Ms Bartley's attendance and it is therefore hard to understand why she was categorised as being unable to work and not offered classes which would have got her out of her cell, mixing with other prisoners and kept her mind occupied.

Applications to the mental health team

189. PID (Prison Information Desk) workers are prisoners responsible for emptying the application boxes on each wing on a daily basis. They record the applications in a book, assigning them a log number and note the application's intended recipient. The applications are collected the same day. Several applications from Ms Bartley were not passed to the mental health team in a timely way. One, dated 4 March, was not seen by the mental health team until 10 March; another, dated 11 March, was not seen until 14 March. A confidential application to the mental health team written on 12 March was not received until 1 April. This is very concerning and unacceptable, particularly given how upset Ms Bartley said she was in some of those applications.
190. As the applications were collected by an administrative worker in healthcare the same day they were written, it would seem that the delay in getting applications to the mental health team lay with the administrative department in healthcare itself. The mental health team told us applications sometimes 'sit' on the Spectrum (healthcare) desk and are not transferred until several have built up over a few days.
191. We also had some concerns about confidentiality issues and did not think PID workers should collect and read prisoner applications which might include details of sensitive physical and mental health issues. We are aware that changes have since been introduced in respect of this.

The Governor and heads of healthcare for Spectrum Healthcare CIC and Nottinghamshire Healthcare NHS Trust should review the healthcare application administration process and ensure that applications are processed in a timely and confidential manner.

Mental healthcare

178. Nottinghamshire Healthcare NHS Trust provides the primary and secondary mental health service. A psychiatrist is available three days a fortnight and there is also an Improving Access to Psychological Therapies (IAPT) practitioner providing cognitive behavioural therapy for short term treatment.
179. The clinical reviewer judged the care given by the mental health service was not equivalent to the care Ms Bartley would have received in the community.
180. The Nursing and Midwifery Council Code of Conduct states that nurses should prioritise people: “You put the interests of people using or needing nursing services first. You make their care and safety your main concern ... and their needs are recognised, assessed and responded to. You make sure that those receiving care are treated with respect, that their rights are upheld ...”
181. Ms Bartley was not treated in line with this statement. The quality of her mental health assessments is poor. There was no reference to past history, poor understanding of medication or involvement with other services. The mental health team meetings appeared perfunctory, processing a large number of referrals but without any real case discussion or consideration of what an appropriate response from the team might be.
182. There were three occasions: 10, 15 and 18 March 2016 when decisions regarding Ms Bartley’s care were made without a face to face assessment. When we spoke to the Matron, he agreed that these were missed opportunities to assess Ms Bartley and that mistakes had been made by his team.
183. It was inappropriate for the mental health team to make decisions about the standard of care offered to Ms Bartley without an up to date face to face assessment. Assessments of Ms Bartley’s mental health and her risk of suicide and self-harm should have been made in response to her applications of 4 and 11 March. Ms Bartley specifically referred to harming herself in both applications and yet no consideration was made as to whether an ACCT should be opened.
184. At the multi-disciplinary mental health team meeting on 18 March those present decided Ms Bartley’s concerns related to her situation on the wing and her behaviour. They decided it was appropriate for the mental health team not to become involved and for the situation to be managed by discipline staff. Within her application Ms Bartley wrote, “I sobbed and was thinking about cutting my throat”. We do not think this was a ‘wing matter’ and think mental health staff should have visited Ms Bartley, opened an ACCT and offered support. The team decided to refer her to the IAPT programme although the time she would spend on the waiting list was longer than the time Ms Bartley had left to serve in prison.
185. When asked, a nurse said he was unable to remember why Ms Bartley was not offered an assessment. He said each referral is only discussed for a short period and Ms Bartley had been discussed several times already at other team meetings. He had stopped working at New Hall by the time of our investigation but told us in written answers he provided: “I can only surmise that our previous dealings with Lynsey intermittently over the previous two years may have played a part in dulling our reactions to her comments. She was ... at times quite

forthright in how she spoke, tending towards such statements as she had written in her application / self-referral form”.

186. The team failed to manage Ms Bartley’s mental health needs appropriately; discussion at team meetings was inadequate and of insufficient depth to properly assess her needs.

The Head of Healthcare should review the mental health assessment process to ensure that accurate, timely assessments of need take place and that these are discussed by the team in a meaningful way to ensure that prisoners are offered mental health interventions that meet their needs.

Concealing medication

187. Some prisoners told us it is very common for women to conceal their medication and sell or exchange it either out of choice or because they are pressurised into doing so. Anything considered ‘saleable’ could be traded for canteen items and some said more than half of prisoners were diverting their medication. The Head of Security & Intelligence also thought prisoners diverted their medication frequently although said that many women arrived in custody carrying medication internally so it was not always clear whether the traded medication was prescribed within prison. They told us there are no proper checks that medication is taken by nurses or officers in the treatment area.

188. A prisoner said Ms Bartley tried to trade some of her prescription medication and that it was not uncommon for her to do this. Whenever she felt under pressure from selling she would request a wing move but on this sentence, Ms Bartley had to remain on Willow House because of the disabled-access cell she occupied. We saw a considerable amount of intelligence suggesting Ms Bartley offered to trade her prescribed medication.

The Governor and Head of Healthcare should review and improve systems to prevent prisoners diverting their medication.

Violence Reduction

192. The Management of Violence Strategy states that the approach taken to manage residents must be constructive and avoid the individual becoming entrenched in problem behaviour. The policy goes on to say it is ‘vital’ that prisoners are encouraged to address the causes of their violent behaviour and that this might include referral to offending behaviour programmes, work with offender supervisors, interventions approved under effective regimes, referrals to healthcare or mental health teams, counselling via the chaplaincy, group work or one to one interviews with the violence reduction co-ordinator.

193. The initial decision to put Ms Bartley onto VR2 on 25 January was reasonable and taken after an investigation into the circumstances of Ms Bartley pressurising another prisoner to order canteen items on her behalf. However, the administration of the VR2 system thereafter was poor and Ms Bartley had few of the interventions suggested in the policy document to help her move forward.

194. The reference to safer custody checks in Ms Bartley's NOMIS case notes seem merely to check that daily entries were being made by staff rather than ensuring the VR2 reviews were held properly and the appropriate paperwork completed.
195. We saw no evidence that any of the case review meetings at the end of each week on VR2 were multi-disciplinary. Although there are template forms in the policy document where VR2 reviews are intended to be recorded we were given no completed forms for Ms Bartley's reviews and suspect that the supervising officers doing the reviews simply wrote a line in her NOMIS case notes instead. Aside from one review by a CM on 12 February, we do not think Ms Bartley's VR2 workbook was reviewed each week as it should have been.
196. The adjudication punishment imposed on Ms Bartley on 15 February coupled with her VR2 regime restrictions meant she had no canteen, no television, no association, no tobacco and was to dine in cell only, from 25 January until 12 March - a period of six and a half weeks. When she was returned to the beginning of VR2 on 12 March, she was facing at least another four weeks on this very restricted regime.
197. Ms Bartley appealed the decision on 13 March using the formal complaint system but the Head of Residence had not decided the outcome by the time of her death. Ms Bartley also wrote several appeals using wing applications, some of which were sent to a CM. The CM said he could not decide the appeal because he was the person who made the decision to put Ms Bartley back to week one and that the appeal should have gone to a governor grade for decision. He said there is no specific form on which to appeal VR2 decisions.
198. We think New Hall's policy on violence reduction is sound, but there is little evidence that Ms Bartley's management was handled in line with it. When she failed to progress through the VR2 programme she should have been put onto VR3 and moved to Sycamore Unit (the segregation unit). The violence reduction policy states that, once on VR3, a governor is to review progress on a weekly basis and the prisoner is required to work with their offender supervisor and personal officer. This would have been an improvement on the care Ms Bartley received on VR2.

The Governor should review the violence reduction policy and how it is implemented, particularly in relation to prisoners with known vulnerabilities. There should be an appeal process.

Management of Ms Bartley's ACCT documents

199. Ms Bartley had three ACCTs opened and closed during her sentence in New Hall. The duty member of the mental health team routinely attends all planned ACCT case reviews. This is best practice and we commend this policy within New Hall.
200. On 26 January, Ms Bartley's ACCT was closed after a case review where she denied any current thoughts of suicide or self-harm. (She had, however, cut her arm with a razor the day before, requiring seven stitches.) Although Ms Bartley told the case review she regretted this and had scared herself, we are surprised by the decision to close her ACCT and think it was premature.

201. An ACCT was opened the next day when Ms Bartley pulled out the stitches in her arm and told the assessor she was struggling with everything. The entries in the ongoing record of the ACCT at the end of January are purely observational but the system is meant to operate as a support system, in addition to the protection that observations alone afford. There is little evidence that officers on Willow House made attempts to get to know, understand or offer support to Ms Bartley during this time.
202. At a case review on 2 February, Ms Bartley asked for some education work to complete in her cell to keep her occupied. A SO emailed the education department about this, but it was not added to the caremap as it should have been and not followed up at the next case review. The ACCT was closed on 9 February after Ms Bartley started to make positive progress through the VR2 system and got along better with staff and prisoners.
203. When Ms Bartley's third ACCT was opened on 24 February the case review should have included a review of her violence reduction status and the adjudication punishment from 15 February. It might have been appropriate to consider whether Ms Bartley should have her television returned, but there is nothing in the written account of the case review to suggest this was discussed.
204. Most case reviews we looked at were attended by someone from the mental health team, but there was rarely anyone else present besides the case manager and Ms Bartley. ACCT reviews should be multi-disciplinary where possible and relevant staff from across the prison should be invited to attend. Ms Bartley had a lot of involvement with nurses who looked after her day to day physical needs, but they were never invited to case reviews. The chaplains, the Supervising Officer who had done the last VR2 review, and officers who had made the most recent entries in the ACCT should have been invited to attend.

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

- **A multi-disciplinary approach for all case reviews with continuity of case management where possible.**
- **Completing ACCT ongoing records fully and accurately, including details of conversations and interactions with prisoners. Purely observational entries should be kept to a minimum.**
- **Setting ACCT caremap actions which are specific and meaningful and which are aimed at reducing prisoners' risks to themselves.**

Assessing the risk of suicide and self-harm

210. Prison Service Instruction 64/2011 (Safer Custody) lists a number of risk factors and triggers that might increase prisoners' risk of suicide or self-harm. After speaking to a prisoner, staff should use their judgement in combination with all available evidence to inform their decision about whether a prisoner poses a risk to herself. While most staff did not think Ms Bartley was the 'type' of prisoner to ever commit suicide, we think several of the listed risk factors became more prominent in the last week of her life and that she was at heightened risk. Her many applications during the week of 12 March show how increasingly desperate

she was for things to change, although it is unclear why she declined the wing move offered by a CM.

211. While completing the violence reduction workbooks as part of her work to progress each week through the VR2 stages, Ms Bartley wrote down many thoughts and feelings. In module two, Ms Bartley said she had cut her arms and tried to hang herself. She stated that she wished she were dead. In module three, Ms Bartley described herself as depressed, low in mood, suicidal and wanting to end her life. In module four, she said she wanted to end her life because everyone hated her and she was sick of her life. We do not know the dates she completed each module and it is unclear who read what she had written. No one doing the violence reduction reviews explored her feelings with her and no new ACCT was opened after the third one was closed on 1 March.
212. There were two missed opportunities for the mental health team to assess Ms Bartley's risk of suicide and self-harm. (There was also another application that did not reach the team before Ms Bartley's death.) On 4 March and 11 March, Ms Bartley wrote applications to mental health asking for help, telling them she was cutting her arms and in the second application, talking about cutting her throat and being scared of what was going on in her head. Despite reading these applications and discussing them in team meetings, no one from the mental health staff did anything to assess or support Ms Bartley or open a further ACCT. The Matron reviewed the applications and decisions made and said he would have expected someone from the mental health team to have spoken to see Ms Bartley to assess her risk of suicide and self-harm. This is a significant failing and has been discussed elsewhere in this report.
213. There were further missed opportunities during the week of 12 March for staff to talk to Ms Bartley and find out how she was feeling about being returned to the beginning of VR2. Ms Bartley made many applications asking for that decision to be reviewed, for a wing move, to do education and speak to her personal officer. Some of the applications do not have dates or reference numbers on them. Few were followed up before her death and it is unclear whether there are any target timescales or a system in place to check the progress of applications.
214. The staff who saw Ms Bartley on 18 March, two CMs and staff from the Together Women project, thought she seemed well and did not have any concerns about suicide or self-harm, albeit that they did not ask her directly how she was feeling. Ms Bartley told some prisoners later that day she felt depressed and thought about ending her life, but none of them alerted staff.

The Governor should review the wing application system to ensure applications have a date, log number and department or name of the recipient. There should be target timescales for responding and a system designed to follow up and ensure applications are answered.

Co-ordination of Ms Bartley's regime and care

215. Overall, we feel New Hall failed Ms Bartley because there was no co-ordinated or properly considered approach to her care. The care offered to Ms Bartley for her physical disabilities was generally appropriate, but more consideration could have been given to the isolating effect of being in a cell on her own, whether she

could attend education (in a wheelchair if necessary) and once off the VR2 restrictions, the dining room for her meals. There were serious shortcomings on the part of the mental health team in failing to assess Ms Bartley despite her making several applications in the last few weeks of her life, asking them for help. Prison staff and managers failed to assess the impact that being on the extremely restricted VR2 regime for several weeks had on Ms Bartley. While there is evidence Ms Bartley tried to sell her medication, she had nothing to do and nobody to talk to, day after day. Prisoners had labelled her a 'grass' and several staff seem to have viewed her as a nuisance. To be told on 12 March, after nearly seven weeks of that regime, that she was to return to the start of the whole process and face at least another four weeks on it, must have been extremely disheartening. Her several appeals about that decision were not properly considered by prison managers or the Independent Monitoring Board. These events, coupled with Ms Bartley's estrangement from her family seem to have become too much to bear.

216. Ms Bartley made several applications during her last week requesting wing moves, to see the mental health team, appealing the VR2 decision and to speak to her personal officer. Nothing seems to have been done in response these applications except that a CM went to speak to her on 18 March. He offered her the wing move she seemed to want so desperately and yet she turned it down. We cannot explain why she decided not to move at this point.
217. Ms Bartley should have been managed as a complex case by New Hall because of her physical health restrictions, mental health needs and violence reduction status. A senior manager should have had overall responsibility to co-ordinate her care and treatment in prison, overseeing the VR2 system, ACCT process, mental health care, physical health care needs, education opportunities, and personal officer input. The manager should have chaired a weekly meeting, bringing together the various departments providing care to Ms Bartley.

The Governor should review how prisoners with complex care needs are identified and managed within New Hall so that such prisoners receive a co-ordinated approach to their care and management by a senior manager.

Personal Officer Scheme

218. New Hall's personal officer policy states that residents will be allocated a 'lead personal officer' but that all members of the 'team' (typically six officers), will be jointly responsible for doing personal officer work with prisoners they are assigned to. The lead personal officer is tasked with introducing him/herself to prisoners within seven days of their arrival and recording this on the case notes. Thereafter, entries must be at least monthly. The Supervising Officers are asked to quality check twenty percent of all case notes per month.
219. There are no entries by the personal officer in Ms Bartley's case notes of a personal officer nature, and he made just one entry, on 15 February, as part of the VR2 daily entries which staff are required to make when someone is on the violence reduction regime.
220. Ms Bartley made a wing application to see her personal officer on 18 March but this was not acted on before her death. We are unsure whether any of the

officers on Willow House really took the time to try and get to know Ms Bartley. There is little to suggest they spent time trying to talk to Ms Bartley or to advise and support her in moving off the VR2 regime.

The Governor should ensure, in line with the personal officer protocol, that personal officers understand their responsibilities, work with prisoners on the violence reduction regime and make regular entries in prisoners' case notes.

Adjudication on 15 February

221. On 4 February, Ms Bartley was charged with “failing to comply with any rule or regulation” because when unlocked to do her ironing she had approached another prisoner’s door and allegedly offered to exchange her medication for tobacco. The Head of Security & Intelligence was the adjudicator on 15 February and Ms Bartley pleaded not guilty. She made a written statement which said she had gone to get the ironing board at the end of the corridor and as she got there, a prisoner shouted out to her from her cell. An officer, who was standing outside the office, told her she should not be at another prisoner’s door, so Ms Bartley apologised and took the ironing board down the corridor ready to use.
222. The Head of Security & Intelligence did not call the other prisoner to ask for her version of events. He told us he did not need to, because Ms Bartley had not denied going to her door; she was denying any such conversation between them. The offence was simply that Ms Bartley was at the door of another prisoner when she had been unlocked to do ironing. The officer, who brought the charge against Ms Bartley, said she heard Ms Bartley tell the prisoner she had 300mg of pregabalin and would exchange it for tobacco.
223. New Hall’s published tariff for the offence of “disobeying or failing to comply with any rule or regulation” states the standard punishment is seven days stoppage of earnings and seven days loss of canteen. The tariff ranges from a caution up to 14 days cellular confinement or a referral to the independent adjudicator. It is not clear from the written charge what rule or regulation Ms Bartley is alleged to have disobeyed. There should have been reference to a signed compact or similar, indicating what rule or regulation Ms Bartley was disobeying.
224. Ms Bartley’s punishment was 14 days cellular confinement, 28 days stoppage of earnings at 75%, 28 days loss of television, association, tobacco and all meals to be eaten in her cell. The impact was, in fact, to impose cellular confinement for 28 days - because she was not deemed fit to go to work – her only time out of cell would be to go on daily exercise periods and for showers. The Head of Security & Intelligence said the punishment was in line with New Hall’s Support and Sanctions policy for trading medication. We are uncomfortable with this, however, because we do not think Ms Bartley was charged with this offence and in any event, think it was not properly explored during the adjudication because the other prisoner was not called to give evidence. He seemed satisfied the offence of failing to comply was met when Ms Bartley went to the prisoner’s door when she should have been ironing, but the punishment he gave was for offering to trade her medication and, in our view, this was not proved beyond reasonable doubt.

The Governor should advise staff of the appropriate adjudication charge to bring when they believe a prisoner has sold, or is attempting to sell, their medication (or illicit drugs) to other prisoners.

Resuscitation

225. Prison and medical staff attempted to resuscitate Ms Bartley. From staff descriptions of Ms Bartley, she had been dead for some time and rigor mortis had set in. The clinical reviewer said attempts at resuscitation were therefore futile. Spectrum Healthcare's resuscitation policy is clear that if rigor mortis or lividity (pooling of blood to the extremities caused by gravity) is present, then resuscitation does not need to be attempted.
226. We understand the commendable wish to attempt and continue resuscitation until death has been pronounced but staff should understand that, in some circumstances, CPR is not required. European Resuscitation Council Guidelines 2010 state, "Resuscitation is inappropriate and should not be provided when there is clear evidence that it will be futile ..." The guidelines define examples of futility as including the presence of rigor mortis. In October 2014, the British Medical Association, the Royal College of Nursing and the Resuscitation Council UK issued guidance about making appropriate decisions about resuscitation. The guidance says that every decision should be based on a careful assessment of the individual's situation and should never be dictated by 'blanket' policies. Trying to resuscitate someone who is clearly dead is distressing for staff and undignified for the deceased.

The Governor should ensure that all staff receive guidance about the circumstances in which resuscitation is inappropriate.

Emergency response

227. The written records of the emergency at New Hall vary significantly in their timings. One of the logs records Ms Bartley being found at 4.53am and the ambulance being called at 5.56am, with the first response paramedic arriving at 5.05am. Nurse B's statement states the request for hotel one was made at 4.43am. Officer D said she began her count around 5.00am. Officer A said he began the count of Willow two at 5.04am and found Ms Bartley moments later. Another officer said he dialled 999 as soon as Officer B asked him to do so.
228. We know from the ambulance service records that the 999 call was made at 5.05am and the ambulance arrived at New Hall's gate at 5.16am. The officer who worked in the control room said that the following morning the New Hall radio clock was found to be between 10 and 15 minutes behind the actual time and that this had led to incorrect times being recorded on some logs.
229. PSI 03/2013, Medical Response Codes, requires governors to have a medical emergency response code protocol and states that all prison staff must be made aware of and understand the protocol and their responsibilities during medical emergencies. The instruction states that, when a medical emergency is called, the control room should call an ambulance immediately and there should be no requirement to wait for a member of healthcare staff or a manager at the scene to confirm that an ambulance is needed. New Hall's local protocol, issued on 21

March 2014 (number 093-14) was not in line with PSI 03/2013 because it instructed control room staff to call an ambulance only if requested to do so by officers or medical staff at the scene of the emergency.

230. Using the term code blue also alerts the responding nurses to the type of emergency they are going to attend so they can know in advance the right equipment to bring, such as a defibrillator. The nurses did not take a defibrillator with them when responding to the request for hotel 1.
231. At the end of our opening visit, we told New Hall that their instruction was not in line with national protocol and advised them to issue a new local instruction as soon as possible in case the prison had another emergency situation. They did so, and on 30 March 2016, published notice 081/16. The instruction tells control room staff to call an ambulance as soon as an emergency code blue or red is used by staff. We do not therefore make a further recommendation about this.

**Prisons &
Probation**

Ombudsman
Independent Investigations