

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Ms Emily Hartley a prisoner at HMP New Hall on 23 April 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.

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

Ms Emily Hartley was found hanged from a gate behind the houseblock where she lived at HMP New Hall on 23 April 2016. She was 21 years old. I offer my condolences to Ms Hartley's family and friends.

Ms Hartley's emotionally unstable personality disorder, together with other risk factors, meant that she was often at high risk of suicide and self-harm. However, I am concerned that the investigation has found that the management of suicide and self-harm procedures, in particular the consequent monitoring and recording, were seriously deficient and that some of these failings appeared systemic. Information sharing was weak and there was a lack of integrated planning, with decisions to curtail Ms Hartley's contact with others for disciplinary reasons running counter to her care needs. The supervision of Ms Hartley on the day she died, while still on suicide prevention measures, was so poor that she was not found for nearly two and a half hours after she was last seen.

I am very concerned by allegations made about bullying on Holly House, a supposedly therapeutic setting, and I expect the Governor to take steps to satisfy herself that the culture and regime on that unit meet the needs of its residents.

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

June 2017

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Summary

Events

1. On 9 May 2015, Ms Emily Hartley was remanded to HMP New Hall, charged with arson. It was her first time in prison. Ms Hartley was prescribed antipsychotic medication and diagnosed with emotionally unstable personality disorder. In October, she was bailed to an approved premises. On 19 November, Ms Hartley was sentenced to two years eight months in prison, and was returned to New Hall. She tested positive for drugs and was put on a methadone detoxification programme. A GP prescribed her antidepressants. Staff monitored Ms Hartley's risk of suicide and self-harm several times between January and March 2016 after she harmed herself, and then continuously from 14 March until she died.
2. Ms Hartley's self-harm and emotional state worsened during March. On 13 April, a GP prescribed an increased antidepressant dosage which Ms Hartley never received, apparently due to an administrative error. The prison arranged for Ms Hartley to see a psychiatrist on 9 May. Ms Hartley's behaviour fluctuated from being positive to suicidal. On 15 April, she harmed herself and put a ligature around her neck. Ms Hartley often spoke to Listeners and the Samaritans.
3. In April, Ms Hartley was found guilty at three disciplinary hearings and received punishments preventing her from mixing with other prisoners during association periods. On 19 April, Ms Hartley told the deputy education manager that no one was listening to her and she was close to killing herself. Ms Hartley said the officers on Holly House (a small unit for women with more complex needs) did not like her and she felt mistreated. The deputy education manager told us that, when he spoke to two officers on Holly House about his concerns for Ms Hartley, he was shocked by their comments. New Hall investigated the matter, but brought no disciplinary charges.
4. An ACCT suicide and self-harm prevention case review on 22 April decided Ms Hartley could move back to Oak House (a residential unit with up to 120 prisoners), and she moved that day. Ms Hartley said she had thoughts of self-harm but not suicide.
5. On 23 April, Ms Hartley called her mother, and told her no one had monitored her for several hours the day before. After lunch, when she was unlocked for exercise, Ms Hartley ran out of the unit ahead of everyone else and went behind the houseblock (where prisoners were not supposed to go). She was out of sight before the other prisoners and the supervising officer came outside. No one completed a log, so the officer in charge of exercise did not know how many prisoners were outside. No one noticed that Ms Hartley was missing for about two and a half hours (even though she should have been locked back in her cell when exercise ended at 3.00pm and monitored throughout as part of ongoing suicide and self-harm prevention (ACCT) procedures). The entries in Ms Hartley's ACCT record do not reflect what happened the day she died and checks were not recorded every 30 minutes as they should have been.
6. At 4.50pm, Ms Hartley was found hanged from a gate behind Oak House. She was cut down immediately and staff began cardiopulmonary resuscitation.

Nursing staff arrived and used a defibrillator, continuing until paramedics arrived. Ms Hartley was pronounced dead at 5.34pm.

Findings

7. Ms Hartley's emotionally unstable personality disorder, together with other risk factors, meant that she was often at high risk of suicide and self-harm.
8. Ms Hartley's ACCT entries for 22 and 23 April do not reflect what she did and are, at times, misleading. Given the requirement for staff to monitor Ms Hartley half hourly, it was unacceptable that no one looked for her all afternoon on 23 April. Had the supervising officer completed the exercise log on 23 April as he should have, Ms Hartley's disappearance from the group would have been noticed much earlier than it was. New Hall has since amended its procedures and all checks by staff are now timed and recorded. The Governor commissioned disciplinary investigations into the actions of some but not all of the staff involved in these events and we consider comprehensive disciplinary investigations are necessary.
9. The decision to move Ms Hartley from Holly House to Oak House the day before she died was in tension with the view of the mental health team leader, although the chair of the ACCT review was unaware of this. It is possible that an enhanced case review approach might have surfaced these tensions. That said, Ms Hartley seemed positive at the ACCT case review on 22 April, had no thoughts of suicide and talked about her future. Accordingly, a decision to return her to Oak House was understandable.
10. Ms Hartley was punished at three disciplinary hearings in April, and lost her association periods from 11 April until she died. The adjudicators did not sufficiently consider the impact this might have on her health and welfare and their punitive approach was at odds with the support and care that Ms Hartley needed because of her suicide and self-harm risk. Again, it is possible that an enhanced case review approach might have surfaced these tensions.
11. We are troubled by the allegations of bullying on Holly House made by Ms Hartley and the deputy education manager. What should have been a supportive regime and environment does not appear to have been so and Ms Hartley was desperate to leave.

Recommendations

- The Governor should ensure that staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including:
 - Following the level of observations and conversations as stated in the 'required frequency' box on the front cover of the ACCT and recording each check immediately or as soon as practicable thereafter
 - Each observation and conversation must be dated and timed. The person making the check must print their name and sign to say they have completed it
 - ACCT observations should be made at irregular intervals to prevent prisoners being able to predict when they will take place

- The Governor should commission a disciplinary investigation into the failure of a SO to count or record the number of prisoners going on exercise on 23 April 2016.
- The Governor should ensure there is a written and accurate record of the number of prisoners going to and returning from exercise each day.
- The Governor should ensure that managers deciding disciplinary hearings and taking subsequent decisions about punishments fully consider the evidence and the likely impact on the health and welfare of the prisoner.
- The Governor should satisfy herself that the culture and regime on Holly House are appropriate to the needs of its residents.

The Investigation Process

15. The initial 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.
16. NHS England commissioned a clinical reviewer to review Ms Hartley's clinical care at the prison.
17. The investigator visited New Hall and obtained copies of relevant extracts from Ms Hartley's prison and medical records. The investigation was subsequently passed to another investigator.
18. The new investigator interviewed 19 members of staff and four prisoners at New Hall in May and June. The clinical reviewer attended the interviews with medical staff. Five staff were subsequently asked to make written answers to questions. The investigator also interviewed a Listener at New Hall in the presence of a Samaritan.
19. We informed HM Coroner for West Yorkshire Eastern District of the investigation, who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
20. One of the Ombudsman's family liaison officers contacted Ms Hartley's mother and grandmother to explain the investigation. They asked us to consider what information the prison had about her daughter's history and whether they knew of an earlier suicide attempt. Ms Hartley's mother asked us to consider how her daughter's risk was assessed by New Hall. She said her daughter had been diagnosed with bipolar disorder and a personality disorder and wanted to know whether she had the correct medication. Ms Hartley's mother said there had been some miscommunication when staff first told her what had happened and that she was not told her daughter had been found hanged.
21. Ms Hartley's family received a copy of the initial report. They provided feedback which has led to some changes. A list of these changes has been provided to recipients of this report.
22. HMPPS provided comments on the report and some changes have been made. A list of these changes has been provided to recipients of this report. A disciplinary investigation into the actions of a supervising officer during the exercise period on the day Ms Hartley died resulted in a first written warning.

Background Information

HMP New Hall

23. HMP New Hall is a closed female local prison, holding around 400 women and young offenders, on remand and sentenced. It can accommodate nine mothers and 10 babies in the mother and baby unit. Primary healthcare services were run by Spectrum Community Health Community Interest Company until August 2016 when it changed to Care UK. Nottinghamshire Healthcare NHS Foundation Trust provides mental health services. Holly House holds a small number of women with complex needs who require more intense staff attention and daily input from mental health staff. Oak House holds a mixed population, including those on drug detoxification.

HM Inspectorate of Prisons

24. 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 safe, with little evidence of violence. Inspectors felt support for women vulnerable to self-harm and those with complex needs was good, although aspects of suicide and self-harm prevention procedures could be improved. Mental health staff were present at most case reviews, but staff from other disciplines rarely attended. Inspectors said relationships between staff and prisoners were a strength and mental health provision was excellent.

Independent Monitoring Board

25. 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 as part of a national benchmarking process.

Previous deaths at HMP New Hall

26. Ms Hartley took her life just over a month after another woman took her life at New Hall. They were the first prisoners to die at New Hall since February 2014. Although there were no notable similarities between the circumstances of the two deaths, we have serious concerns about the co-ordination of care of both women. Since Ms Hartley’s death, two more prisoners have died and we are currently investigating the circumstances of those deaths.

Assessment, Care in Custody and Teamwork (ACCT)

27. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner. After an initial assessment of the prisoner’s main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular multi-disciplinary review meetings involving the

prisoner. As part of the process, a caremap (plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the caremap have been completed.

28. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Key Events

Initial period at New Hall

29. On 11 May 2015, Ms Hartley was remanded to HMP New Hall, charged with arson. It was her first time in prison. She arrived from court with a suicide and self-harm warning form having self-harmed the previous day. The police national computer indicated that she had previously been detained in a mental health hospital for assessment. ACCT monitoring was begun and apart from a three week break in June continued until 2 September.
30. In July, a prison psychiatrist prescribed an antidepressant and both he and an independent psychiatrist assessed Ms Hartley and felt she should be transferred to a secure hospital. In August, another psychiatrist wrote a court report, which concluded that Ms Hartley did not need to be hospitalised and was fit to stand trial. On 21 October 2015, at a court hearing, Ms Hartley was bailed to an approved premise. While out of prison, Ms Hartley began to take drugs again.

19 November 2015 – 22 March 2016

31. On 19 November, Ms Hartley was sentenced to two years and eight months in prison for arson and was returned to New Hall. In reception, she tested positive for cocaine and benzodiazepines and said she smoked heroin. Ms Hartley was referred to the substance misuse team and saw a GP who prescribed an antidepressant and methadone. The methadone was prescribed on a gradually reducing dose, starting at 30mls. By April 2016, Ms Hartley was taking 12mls daily.
32. A nurse met Ms Hartley on 14 December and told her she would start the CARE (Choices Actions Relationships Emotions) programme in April-May 2016. This course was then rescheduled for August (which meant Ms Hartley would not have had sufficient time left in prison to complete the course).
33. Between 11 January 2016 and 10 March Ms Hartley had four periods of ACCT monitoring - 11 January to 12 January 2016 when she told an officer she felt down and cut her wrist, 11 February to 17 February 2016 when she said she was being bullied by another prisoner and cut her wrist, 25 February to 8 March 2016 when she broke a pot and said she wanted to cut herself with it, 9 March to 10 March 2016 when she made cuts to her arm after an argument with another prisoner (who was subsequently moved).
34. A prisoner met Ms Hartley on 7 March and said they were in a relationship for two or three weeks towards the end of March, before she moved to a different unit in New Hall. Ms Hartley told her mother in a letter that she did not want to be in a relationship with her.
35. On 14 March, an ACCT was opened after Ms Hartley cut her arm because of issues that had arisen in art therapy. Observations were set at two per hour.
36. Ms Hartley applied for release on home detention curfew. No suitable address could be found. This meant that she had to stay in prison until 6 October 2016.

22 March to 12 April 2016 - Oak House

37. On 27 March Ms Hartley asked to see a psychiatrist about sleeping medication, anxiety and self-harm issues. A nurse replied on 30 March but did not think Ms Hartley's risk level had increased. He told her he was leaving New Hall and she would be allocated another mental health worker.
38. On 4 April, the mental health team, including a psychiatrist, felt Ms Hartley remained at high risk of self-harm. A new one-to-one worker with experience of working with people with personality disorders took Ms Hartley onto her caseload.
39. On 9 April, an officer wrote in the ACCT that Ms Hartley had been talkative and approachable in the afternoon, but had become quiet and withdrawn later. Ms Hartley cut herself, said she had strong thoughts about setting fire to herself, swallowing razor blades and writing a suicide note. She was put in a safer cell and her lighter was removed for her own safety. A SO (Supervising Officer) explained to Ms Hartley that she needed to press her cell bell when she wanted a light for a cigarette and noted this in the wing observation book.
40. The next day, in line with this arrangement, Ms Hartley pressed her cell bell and asked for a light. A custodial manager said Ms Hartley demanded a lighter and became abusive and swore at her when she refused. She told her it was not the correct use of the cell bell and subsequently charged her with an offence against prison discipline for her threatening and abusive behaviour. At an ACCT case review in the afternoon, Ms Hartley said she had felt low but was not thinking about suicide. Her observations remained at two per hour.
41. On 11 April, at the disciplinary hearing for being abusive, the adjudicating governor did not call the custodial manager or the SO as witnesses. Ms Hartley apologised for her behaviour, was found guilty and was punished with seven days' loss of canteen and five days' loss of association.
42. On 11 April, at an ACCT case review, Ms Hartley was distressed and said she felt negative. She wanted to come out of the safer cell (but was told she could not). Observations were kept at two per hour. The mental health team felt Ms Hartley's self-harm had increased and her mood had deteriorated. The next day, a SO saw that Ms Hartley had injured her neck with a piece of broken pot. A nurse checked her injury and Ms Hartley was moved to a cell in Holly House with CCTV to assist staff with monitoring.

12 to 22 April 2016 - Holly House

43. On 13 April, at an ACCT case review, Ms Hartley exuded confidence, talked about going to college and was animated about her plans. A custodial manager decided to keep Ms Hartley at Holly House to find out more about her and what triggered her self-harm.
44. Later, Ms Hartley had a GP appointment and told the GP her antidepressants were not helping and her mental state had deteriorated. She described racing thoughts and feeling low, irritable, at risk of self-harm and asked for antipsychotic medication. He increased the dose of mirtazapine to 30mgs per day and contacted the mental health team. The increased dosage was ordered as two sets of 15mg tablets. Ms Hartley did not receive the increased prescription

because healthcare staff thought she had been prescribed a double dose in error. A routine psychiatrist appointment was made.

45. On 15 April, an officer placed Ms Hartley on report for using threatening and abusive behaviour. Ms Hartley re-opened a wound on her arm, tied a ligature around her neck and attached it to a tap. She refused treatment. Ms Hartley spoke to her one-to-one worker and showed her a suicide note (written a few days earlier), said her art therapy class had brought up a lot of issues and that she had been banging her head against the wall.
46. On 16 April, at the disciplinary hearing for being abusive towards an officer, Ms Hartley was found guilty and received a punishment of seven days' loss of association and seven days' loss of earnings at 70 percent from the Head of Residence and Safety at New Hall.
47. Ms Hartley wrote a letter to the psychiatrist, in which she said she wanted to end her problems. On 18 April, the mental health team discussed Ms Hartley but without sight of the letter. A GP and other mental health staff noted Ms Hartley's increased risk to herself and deterioration in mood. The appointment with the psychiatrist was made for 9 May (a normal wait for a routine appointment).

19 April 2016

48. Ms Hartley told a nurse she was expecting to go back to Oak House. She was more agitated than usual at education in the morning, smashed a drawer in her cabinet and was charged with an offence against prison discipline.
49. The deputy Head of Education spoke to Ms Hartley in the afternoon. Ms Hartley said no one was listening to her, she could not sleep, was not getting the medication she needed and was getting worse. She thought people would listen to her if she "kicked off". She felt staff were bullying her and was agitated, anxious and tearful at times. She showed him a ligature mark on her neck and self-harm marks on her arms. Said she was close to killing herself and wanted to leave Holly House, would rather be in the segregation unit and might assault a member of staff.
50. When the deputy Head of Education spoke to two healthcare officers, he alleged their reply was that they hoped she did "kick off" as they wanted an excuse to "take Emily down" and said "she'll go down with some speed". He said one officer said she wanted Ms Hartley to call her an abusive name again so that she could slap her around her face. New Hall subsequently commissioned a preliminary disciplinary investigation into these allegations. The outcome was inconclusive and no further action was taken against the officers but both were spoken to subsequently by the Governor.
51. At an ACCT case review, Ms Hartley was loud, aggressive and threatening. She demanded a move from her from Holly House and said some staff were bullying her but gave no names or examples. A custodial manager advised her to make a confidential access complaint, which would be investigated by a governor. Ms Hartley said her threats to kill herself were an impulsive comment to the deputy Head of Education, but ACCT observations were nonetheless increased to four per hour.

52. Ms Hartley made a formal complaint about some healthcare staff and said it felt like a punishment to be in Holly House and listed several issues such as staff hating her, not answering her cell bell in times of emergency, constantly telling her off about her messy room, not letting her take a shower regularly, not letting her speak to the Listeners more than once a day, ignoring her and smirking at her when she was upset. Ms Hartley's complaint had not been answered at the time of her death.
53. On 21 April, a governor held a disciplinary hearing about the damaged drawer. Ms Hartley told him she broke the drawer in order to harm herself. He did not accept Ms Hartley's version of events. Ms Hartley's punishment was seven days' loss of canteen and five days' loss of association, plus paying for the cost of the drawer.
54. The cumulative effect of this and previous punishments was that Ms Hartley lost her association continuously from 11 to 26 April.
55. A nurse saw Ms Hartley as part of the routine mental health rounds at Holly House and Ms Hartley said her mirtazapine was meant to be raised to 30mg but had not been. We have seen no evidence that this was investigated further, as it should have been.

22 April 2016 – Oak House

56. At an ACCT review at 8.35am, Ms Hartley said she had thoughts of self-harm, but not of suicide. She appeared bright, relaxed, had good eye contact and seemed positive about her future. A member of the mental health team was present and agreed to the proposed return to Oak House. The review reduced Ms Hartley's observations to two per hour. Ms Hartley moved to Oak House after the review, and was placed in a safer cell (with no ligature points). As Ms Hartley walked from Holly House to Oak House, she saw a prisoner returning from education. They spoke for 20 – 30 seconds and the prisoner gave Ms Hartley her lighter. The prisoner thought she was preoccupied and distant. They had no further contact.
57. At lunchtime, another prisoner said Ms Hartley said, "I won't be here on Monday". She thought Ms Hartley had wanted to die for weeks and felt it was inevitable that at some point, she would succeed. She said she told SO A, the supervising officer on Oak House, that Ms Hartley had threatened to kill herself but was told that Ms Hartley was in a safe cell and her risk was being monitored. He said the prisoner did come to the office but did not say anything about Ms Hartley not being there on Monday. He said she came to the office and told him a prisoner had threatened her.
58. Ms Hartley was given the Samaritans phone at 1.00pm. Staff noted she was watching television at 1.30pm. Records show Ms Hartley pressed her cell bell at 2.44pm, 4.01pm and 4.46pm. An officer made entries at half hourly intervals from 2.00pm to 4.30pm in Ms Hartley's ACCT record to say Ms Hartley was, "in room – no issues". His entry at 5.00pm, at odds with the earlier entries, said, "Emily has spent the afternoon on association, she has raised no issues. Handover to Officer X, obs at 2 per hour". We asked the officer why he made these entries but he could not recall. Ms Hartley should not have been on

association because of the adjudication punishment. In a phone call to her mother the next day, Ms Hartley said that no one had checked her wellbeing all afternoon. New Hall subsequently commissioned an investigation into this and the ACCT entries made on 23 April and the officer appeared at a disciplinary hearing following which he received a written warning and underwent priority ACCT training.

59. At 6.00pm, Ms Hartley asked to speak to a Listener. Listeners work on a rota system and in pairs (for moral support and safeguarding). A prisoner was one of the Listeners who met with Ms Hartley and they spoke for about an hour. Nothing is written down by the Listeners about what they discuss with prisoners.

23 April 2016

60. An officer remembered answering Ms Hartley's cell bell and Ms Hartley asked if she could have a shower. He said she could come out at 11.00am for a shower. He answered her cell bell again at 10.50am, and agreed she could come out of her cell for the rest of the morning.
61. Around 11.00am, Ms Hartley spoke to SO A, and read him two poems. The SO did not think she was stressed or upset. Ms Hartley telephoned her mother just before midday and told her "I think I'm manic or getting there". Ms Hartley said she was supposed to be monitored with two checks an hour, but no one had checked on her from 12.00pm until 6.00pm the day before. She said that if she had killed herself in the first half an hour, it would be five and a half hours before staff found her. She said, "That's ridiculous that isn't it" and then, "I'm not saying I'm gonna, but if I did, they wouldn't find me".
62. An officer thought Ms Hartley was out of her cell (notwithstanding the extant punishment) between 9.00am and 12.00pm. He made an entry in Ms Hartley's ACCT at 12.00pm which read, "No issues this morning, been chatting to friends and staff. No visual signs of self-harm. Handover to Officer X". He said he was not the officer responsible for watching Ms Hartley that morning, but remembered seeing Ms Hartley a couple of times.
63. At 12.40pm, an officer answered Ms Hartley's cell bell and gave her a light for her cigarette. Two entries were made in the ACCT document at 1.00pm and 1.30pm, which read "Given light, states okay" and "Laid in bed, states okay". It does not say who made these entries or when they were made. Ms Hartley asked a nurse for more paracetamol at 1.57pm.
64. An officer wrote in Ms Hartley's ACCT document at 3.00pm "To o/s exercise". Despite Ms Hartley's observations being set at half hourly intervals, this was the last entry in her ACCT record and was inaccurate - exercise started around 2.25pm and finished at 3.00pm. Ms Hartley was not seen at 3.00pm as the entry in the ACCT implies.
65. The exercise area for Oak House prisoners was not an enclosed exercise yard. (Since Ms Hartley's death, it has been moved to another area.) Prisoners were expected to stay within a small area to the front of Oak House that staff could supervise. There were no physical barriers preventing women from leaving the exercise area. SO A said he saw Ms Hartley as he called for the start of the

exercise period at around 2.20pm. He thought Officer A searched Ms Hartley and took some letters and poems from her. The officer said she did not search Ms Hartley and it is unclear whether Ms Hartley was searched before going on exercise. Ms Hartley had wrapped some bed sheet around her middle underneath the sweatshirt she was wearing. Ms Hartley was the first prisoner to go outside and CCTV footage shows her running out of the main entrance of Oak House and reaching the corner of the unit at 2.27:47pm. After looking up, she ran to the back of the houseblock. About 10 seconds later, the other prisoners going on exercise emerged from the main entrance. Ms Hartley was already out of sight.

66. SO A went onto the exercise area to supervise the prisoners for a few minutes before asking Officer A to take over. No one completed the exercise log sheet to record the number of prisoners outside. The SO said no sheet was available. The prisoners asked to go inside early because they were cold. Exercise ended around 3.00pm and the officer counted 18 prisoners back in. No one noticed that Ms Hartley was not there. Further 30 minute ACCT checks and observations of Ms Hartley should have happened from 3.30pm onwards. They did not.
67. Around 4.20pm, Officer B went to Ms Hartley's cell to unlock her for tea, but she was not there. He looked around the unit and then called her name over the wing Tannoy system asking her to go to the office. Another officer told him that Ms Hartley had not collected her meal at 4.30pm. Officer B became concerned and told SO A. The SO telephoned the control room at 4.46pm, asking them to use the CCTV cameras to look for Ms Hartley. He called the orderly officer and asked staff to lock prisoners in their cells and search for Ms Hartley.
68. SO A and Officer C searched outside Oak House. The SO found Ms Hartley around the back of Oak House, suspended from a metal gate with a torn piece of bed sheet as a ligature. He radioed for help but did not use the term code blue as he should have done to alert the control room to ask for an emergency ambulance. The control room had used CCTV camera to follow the SO and saw him discover Ms Hartley. They called an emergency ambulance immediately at 4.50pm.
69. Officer C arrived and supported Ms Hartley while the SO cut the ligature. The officer began chest compressions. Ms Hartley was very cold and her skin looked grey. The orderly officer arrived moments later and tried to radio a medical emergency code blue but her radio battery was flat. Officer A arrived and radioed for immediate assistance. A nurse and a healthcare assistant (HCA) responded. The nurse said Ms Hartley had a deep ligature mark around her neck. She helped give chest compressions and the HCA used an ambu bag to give breaths. The nurse noticed Ms Hartley had written 'DNR' (Do Not Resuscitate) on her arm in black pen, but said this was not viewed as an official decision and so they continued to try and resuscitate Ms Hartley. A defibrillator did not administer any shocks. An airway was inserted and oxygen given but there was no response.
70. The ambulance service rapid response car arrived at New Hall's gate at 4.59pm, and the rapid responder reached Ms Hartley at 5.03pm. An ambulance arrived at

5.06pm with more ambulance staff. Despite efforts to resuscitate Ms Hartley, the paramedics pronounced her death at 5.34pm.

Comments from prisoners

71. At a subsequent interview, a prisoner said she thought Ms Hartley was worried and upset about not getting release on home detention curfew at her mother's address; her mental healthcare; her self-harm; her father visiting her unexpectedly; and having been raped twice.
72. We have seen intelligence suggesting that a prisoner told a nurse that Ms Hartley and she had a suicide pact. The prisoner denied this but said she had told Ms Hartley in March that she "could not live without her" and Ms Hartley had said something similar in response. She thought Ms Hartley took her life because it was the first opportunity she had had to do so since being refused release on home detention curfew.

Anonymous text messages

73. During the latter stages of our investigation the investigator received three anonymous text messages giving information about the circumstances leading to Ms Hartley's death, specifically the move to Holly House and Ms Hartley's conversation with another prisoner. The information provided was already known to us and is reflected in this report, having been followed up with staff and prisoners. We asked the sender of the texts to identify themselves to enable us to discuss further, but have not received any reply.

Contact with the family

74. At 8.00pm, a trained family liaison officer, a chaplain and an officer left New Hall to visit Ms Hartley's mother. The family liaison officer told Ms Hartley's mother that Ms Hartley had taken her life, and offered her condolences. Ms Hartley's mother told us that the prison family liaison did not tell her how her daughter had died, despite her asking. The family liaison officer denied this and said Ms Hartley's mother did not ask for details. She said it was difficult to know how much information to give because the family were understandably shocked and upset.
75. Another officer was subsequently appointed as the family liaison officer and maintained regular contact with Ms Hartley's mother. The prison contributed to the costs of the funeral, in line with national policy.

Support for prisoners and staff

76. A governor and the duty governor debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support. The prison posted notices informing staff and prisoners of Ms Hartley'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 Hartley's death.

Post-mortem report

77. The post-mortem examination found Ms Hartley died from hanging. Toxicology tests confirmed the presence of methadone, mirtazapine, paracetamol and ibuprofen. All were within the therapeutic range.

Findings

Suicide prevention, management and staff supervision

78. 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, including deliberate self-harm, mental health diagnosis, hopelessness, impulsiveness, lack of social support and relationship instability. 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. Ms Hartley's diagnosis of emotionally unstable personality disorder meant she was often at high risk of suicide and self-harm. Several staff described how she would quickly go from being bubbly and chatty and talking about her future to feeling low and that she could not cope, but then become positive equally quickly. This made it difficult for staff to assess Ms Hartley's risk of suicide and self-harm and by the very nature of her personality disorder, it changed frequently.
79. ACCT reviews should be multi-disciplinary where possible. As with our last investigation of a death at New Hall, there was evidence that the mental health team routinely attending planned ACCT case reviews, which is good practice. It would have been appropriate for Ms Hartley's IT teacher (who knew her well), art therapy teacher and the chaplain also to have participated in case reviews. We asked New Hall to make case reviews more multi-disciplinary in our last report issued shortly before this one, and expect them to address that recommendation.
80. A named officer should have been responsible for monitoring each prisoner subject to ACCT procedures. This did not happen. Officers had joint responsibility for checking prisoners, which meant in practice that no one took responsibility. The practice for checking prisoners subject to ACCT monitoring at New Hall was not in line with nationally accepted practice. If a prisoner was unlocked (for work or education, for example), staff were expected to check the prisoner periodically, but not to update the ongoing ACCT record until the end of the association or work period, when they would make a general entry. The Head of Safer Custody said it had become the default position not to record observations. The consequences of this practice are highly material.
81. Ms Hartley's ACCT entries for 22 and 23 April do not accurately reflect what she did during the morning. For more than two hours after the exercise period, no one looked for her, despite 30 minute observations being required. The entries in her ACCT are inaccurate and misleading and demonstrate an absence of supervision, support and monitoring.
82. It is striking that Ms Hartley spoke to her mother on the day she died and said that no one had checked her for several hours the previous day. She even said that if she were to take her life, officers would not find her for many hours. This is exactly what happened later that day.
83. New Hall subsequently commissioned disciplinary investigations into the actions of some staff on 22 and 23 April, and Officer B and another officer appeared before a disciplinary hearing. Both officers were given written warnings and attended ACCT training courses.

84. We were very concerned about the lack of recorded observations, but note that the Governor has addressed this since Ms Hartley's death and that every ACCT observation is now timed and recorded.
85. We discuss below the specific issues of Ms Hartley's location and disciplinary punishments and the tensions these exposed in caring for her under suicide and self-harm procedures. We have considered whether an enhanced case management approach might have mitigated these tensions, improved information sharing and ensured a more holistic approach to Ms Hartley's care. We recognise that staff considered and rejected this approach as they did not believe Ms Hartley reached the threshold for enhanced case management set out in national policy. This is a matter of judgment and so we do not make a recommendation, but the consequent management of ACCT was seriously deficient call and we make the following recommendations:

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

- **Following the level of observations and conversations as stated in the 'required frequency' box on the front cover of the ACCT and recording each check immediately or as soon as practicable thereafter**
 - **Each observation and conversation must be dated and timed. The person making the check must print their name and sign to say they have completed it**
 - **ACCT observations should be made at irregular intervals to prevent prisoners being able to predict when they will take place**
86. Staff told us that the exercise yard log is usually completed each day. SO A said there was no log available to complete on 23 April but other staff said, even if no log was available, he could have logged the number of prisoners on paper. This did not happen, and there was no reasonable excuse for it. Had he counted and recorded the number of prisoners, Ms Hartley's disappearance from the group would have been noticed earlier, potentially with life-saving consequences. When Officer A took over supervising the exercise period, she received no handover about the number of women outside and could not have known whether someone was missing when she made her own count.

The Governor should commission a disciplinary investigation into the failure of the SO to count or record the number of prisoners going on exercise on 23 April 2016.

The Governor should ensure there is a written and accurate record of the number of prisoners going to and returning from exercise each day.

Disciplinary charges

87. Ms Hartley was found guilty at three disciplinary hearings in April, and by way of punishment, lost her association period each time, along with other punishments.
88. On 11 April, Ms Hartley was punished with five days loss of association for using threatening, abusive or insulting words or behaviour towards a custodial manager

after she refused to give Ms Hartley a light for her cigarette. This was just below the standard punishment at New Hall for such an offence, but we do not think the adjudicator:

- considered the mitigating circumstances that led up to the offence - Ms Hartley had been told by SO A to press her cell bell when she needed a light.
- tested the evidence sufficiently or explored the mitigating circumstances but relied instead on Ms Hartley's guilty plea – he did not call the custodial manager to ask whether she had read the observation book where SO A had written that Ms Hartley was to press her cell bell when she needed a light.
- took into account Ms Hartley's mental health issues - she struggled to control her emotions and reactions and her outburst followed several days of self-harm, feeling low and speaking to Listeners.

89. On 16 April Ms Hartley was given seven days loss of association for being verbally abusive towards an officer. This was just as her five days loss of association was ending from the previous punishment. Although on the face of it there were not the same mitigating circumstances as in the previous adjudication, we feel a further seven days loss of association did not take into account the fact that Ms Hartley was in a period of crisis around this time and had been put in Holly House for additional support.
90. Prison Service Instruction 47/2011 on prison discipline procedures says prisoners should not normally be charged when their action related to self-harm and requires adjudicators to take account of the likely impact of the punishment on the prisoner, including their health and welfare. While the disciplinary hearings were narrowly in line with procedure, the decisions failed to consider mitigating circumstances, test the evidence sufficiently or take into account Ms Hartley's mental health issues. The punishments were cumulatively disproportionate, and overall meant Ms Hartley lost all of her association periods from 11 April until she died. This punitive effect was at odds with the support and care that Ms Hartley needed.
91. In a review, Learning from PPO Investigations, published in March 2015, setting out learning from self-inflicted deaths in prisons in 2013/14, we noted that a number of prisoners who killed themselves had had less than two hours a day out of their cell in the week before they died, and this had increased significantly from the year before. We identified that the cumulative impact of restrictions on regime such as segregation, adjudication punishments and access to work needed to be taken into account. Lack of activity can leave vulnerable prisoners even more at risk. We are concerned that there was little evidence that staff considered the impact of Ms Hartley's restricted regime on her mental wellbeing. Our investigation into the death of a woman the month before Ms Hartley's death also raised concerns about the cumulative effect of regime restrictions. We make the following recommendation:

The Governor should ensure that managers deciding disciplinary hearings and taking subsequent decisions about punishments, fully consider the evidence and the likely impact on the health and welfare of the prisoner.

Location of Ms Hartley

92. Ms Hartley moved to Holly House on 12 April and remained there until the ACCT case review on 22 April which decided she should return to Oak House. The mental healthcare team leader felt that Ms Hartley should remain at Holly House, as it provided a safer environment. Ms Hartley had been emotionally unstable during the week before the ACCT case review of 22 April:
- She had put a ligature around her neck and cut herself on 15 April.
 - She wrote to the psychiatrist on 18 April saying she wanted to permanently end her problems and wrote about battling with feelings of wanting to die.
 - She told the deputy Head of Education she wanted to die on 19 April and smashed a cabinet drawer.
 - She told a nurse she banged her head against the wall on 21 April.
93. A nurse, who represented the mental team at the ACCT review on 22 April, felt Ms Hartley was deteriorating at Holly House. She believed Ms Hartley would be safe on Oak House because she was to live in a safer cell and staff were to monitor her every 30 minutes. The custodial manager who chaired the review did not know the mental health team leader was advising against her relocation and told us she would not have moved Ms Hartley had she known of his concerns.
94. Ms Hartley wanted to leave Holly House where she found the regime restrictive and struggled with the rules about smoking. She felt bullied and mistreated by officers (we discuss this further below). Had Ms Hartley felt more supported by officers on Holly House, she may have wanted to remain there. Despite poor information sharing and an uncoordinated approach, we can understand the decision to move Ms Hartley to Oak House and feel the real failing was the lack of monitoring and supervision once back on Oak, rather than the decision to move her from Holly.

Allegations of bullying

95. Ms Hartley spoke to the deputy Head of Education on 19 April about feeling mistreated and bullied by staff on Holly House. Ms Hartley repeated some of this to a custodial manager at an ACCT review later that day and to her mother when she spoke to her on the telephone after moving to Oak House. The deputy Head of Education spoke to officers on Holly House about his concerns for Ms Hartley and was troubled by their attitude towards her. Although the matter was investigated locally, no conclusive findings were drawn. The Governor subsequently spoke to all of the staff involved.
96. A custodial manager said Holly House is a small unit that is quite often used for a respite period for people and has daily mental health input and support. The unit

allows residents to refocus and have time away from the big residential units. It does however have some restrictive practices, such as when residents are permitted to have a cigarette. While we acknowledge that many of the women on Holly House will be more challenging to manage than those who live elsewhere in New Hall, we are disturbed by the allegations Ms Hartley and the deputy Head of Education made about their treatment by staff who work there. What should have been a supportive regime and environment for Ms Hartley appears not to have been so – she evidently felt oppressed, bullied and badly treated. We recommend:

The Governor should satisfy herself that the culture and regime on Holly House are appropriate to the needs of its residents.

Clinical care and mental health care

97. The clinical reviewer judged the care given by primary healthcare and the mental health service was at least the equivalent to the care Ms Hartley would have received in the community. During Ms Hartley's first period in New Hall from May 2015 to October 2015 she was suffering from a psychotic disorder. She improved with drug treatment and by the time of her release was mentally well and off all psychiatric medication. When Ms Hartley returned to the prison the following month her presentation was in keeping with an earlier diagnosis of emotionally unstable personality disorder, for which there is no drug treatment. The one-to-one worker had just started doing some work with Ms Hartley shortly before her death.
98. The mental health team meeting on 19 April, which included a psychiatrist, noted Ms Hartley's increase in self-harm and mood deterioration. She was referred for a psychiatric review. The clinical reviewer said in her clinical opinion, people with emotionally unstable personality disorder change daily and the medical record and ACCT entries about Ms Hartley demonstrate this; one minute she was bright, the next, down. The clinical reviewer said prescribing psychiatric medication would not have changed this and there were no indications of psychosis around this time. She therefore felt it was reasonable that the referral to the psychiatrist was a routine, rather than urgent one.

Emergency response

99. PSI 03/2013 requires prisons to have a medical emergency response code protocol that ensures that an ambulance is called automatically in a life-threatening medical emergency. At the end of our opening visit into a death at New Hall a month before Ms Hartley died, we told New Hall that their instruction on emergency responses was not in line with national protocol and advised them to issue a new instruction as soon as possible, in case New Hall had another emergency situation. They did so, and on 30 March 2016, published notice 081/16, which instructed control room staff to call an ambulance as soon as staff used an emergency code blue or red. Control room staff were proactive in calling an ambulance when they saw on CCTV that SO A had found Ms Hartley. While we recognise that neither the SO nor Officer A radioed a code blue, as they should have done, we are satisfied that there was no delay in the emergency response.

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