

**Investigation into the death of a woman  
at HMP & YOI New Hall in September 2011**

**Report by the Prisons and Probation Ombudsman  
for England and Wales**

**July 2013**

This is the report of the investigation into the death of a woman, a prisoner at HMP & YOI New Hall. She was found dead in her bed one morning in September 2011. She was 24 years old. The post-mortem examination concluded that her sudden death was the result of heart disease and could have occurred suddenly at any time. I offer my condolences to her family and friends.

The investigation was carried out by an investigator. The local Primary Care Trust commissioned a clinical reviewer to review the clinical care the woman received at New Hall. New Hall cooperated with this investigation. I apologise for the late issue of this report.

The woman was sentenced to life imprisonment in December 2007. In January 2008, she suffered a cardiac arrest, as a result of low blood potassium, which was subsequently attributed to an eating disorder, and was admitted to hospital for treatment. In April 2008, while still in hospital, she was admitted to Stockton Hall Hospital to treat her eating disorder. She returned to New Hall in June 2010.

After her return to the prison the woman exercised regularly and was employed as a gym orderly. She was not Muslim but chose not to eat during the day for some of the Ramadan period, the month before her death. We are satisfied that this did not affect her health. Her potassium levels continued to be tested and were within normal limits. She had not reported any chest pains or being unwell, either to prison staff or other prisoners before her death.

The clinical reviewer concluded that the woman had every general health and mental health intervention and care possible to support her during her time in New Hall. While I make some recommendations aimed at improving some aspects of health procedures these would not have changed the outcome for her. I am satisfied that there is nothing that staff at New Hall could have done to prevent her sudden and unexpected death.

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

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**July 2013**

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## SUMMARY

1. The woman had a history of alcohol and drug abuse from an early age and previously served a custodial sentence at New Hall in 2002 for six months
2. On 24 March 2007 the woman was remanded into prison at HMP New Hall where she was placed on an alcohol and drug detoxification programme. She returned to court on 3 December 2007 and was sentenced to life imprisonment for murder. She returned to New Hall.
3. In January 2008, the woman suffered a cardiac arrest and was taken to hospital. She was diagnosed with hypokalaemia (lower than normal amount of potassium in the blood) as a result of bulimia nervosa (this is an eating disorder which includes bingeing on food followed by self induced vomiting). She returned to New Hall on 11 February 2008, but was re-admitted to hospital on 26 February 2008, after a deterioration in her blood potassium level.
4. The woman's mental health was assessed while she was in hospital and she was sectioned under the Mental Health Act. She transferred to a psychiatric hospital on 14 April 2008. After it was considered that her eating disorder was under control, she returned to New Hall in June 2010.
5. The woman became a gym orderly at New Hall and spent most of her spare time in the gym exercising daily. Staff believed she was in control of her eating disorder but she appeared to exercise almost obsessively. She was seen regularly by the mental health team and her potassium levels were regularly monitored.
6. In August 2011 the woman broke her ankle and could not use the gym to exercise. Although she was a not Muslim she chose to fast between the hours of sunrise and sunset for at least part of Ramadan (which lasted for the month of August).
7. One morning in September, a prison officer unlocking cells found the woman still in her bed, which was unusual. The officer attempted to wake her but there was no response and emergency medical assistance was requested. Healthcare staff could not find any signs of life and it was evident she had been dead for some time. Resuscitation was therefore not attempted. Paramedics attended and confirmed she had died at 8.54am.
8. The prison family liaison officer maintained contact with the woman's family and offered support and financial assistance towards the funeral expenses.
9. The woman's death was sudden and unexpected, and we accept that staff at New Hall could not have done anything to prevent it. However, some areas for improvement in procedures were identified during the investigation and we make four recommendations about awareness of eating disorders and assessment for gym use.

## THE INVESTIGATION PROCESS

10. The Ombudsman's office was notified of the woman's death on 12 September 2011. The investigator issued notices to staff and prisoners informing them of the investigation and inviting anyone with relevant information to contact her. Three prisoners came forward as a result.
11. An Assistant Ombudsman visited New Hall on 21 September. She saw the woman's cell and the gym and collected copies of her prison records, including her medical record. She met representatives of the Independent Monitoring Board and the Prison Officers Association.
12. The investigator visited New Hall on 16 November and interviewed four members of staff and one prisoner. On 16 December, she interviewed by telephone another prisoner who had moved from New Hall.
13. The Assistant Ombudsman returned to New Hall on 27 February 2012, and interviewed five members of staff and one prisoner. She gave feedback to the Governor at the end of her visit which was followed up in writing.
14. The local Primary Care Trust (PCT) commissioned a clinical reviewer to carry out a review of the woman's clinical care at New Hall. She completed her review on 24 January 2012.
15. HM Coroner for West Yorkshire Eastern District was informed of the investigation and provided the results of the post-mortem. The Coroner will be sent a copy of this investigation report.
16. One of the Ombudsman's family liaison officers contacted the woman's mother. She explained the purpose of the investigation and provided the opportunity for her to identify any particular concerns about her daughter's care at New Hall. She wanted to know more about the circumstances of her daughter's death and in particular whether she should have been allowed to take part in fasting for Ramadan, having previously suffered a near fatal condition, due to low potassium levels.
17. As part of the consultation, the woman's family, partner and their legal representatives received a copy of the draft report. Their main concern was that the prison knew she had been returned to custody from psychiatric care and that she had been treated for an eating disorder, yet she was allowed to access the gym as frequently as she wanted, with no fitness screening, no real supervision, no monitoring of her gym use and no regular health care input in place to monitor her heart condition. The family were satisfied that the PPO report covers these issues.

## **HMP & YOI NEW HALL**

18. HMP & YOI New Hall is a closed female prison which holds up to 446 adult women. It has a mother and baby unit and also holds young offenders and girls under eighteen on detention and training orders. There are three main residential units, Oak, Willow and Poplar. Most of the accommodation is in single cells.
19. Primary healthcare at New Hall was commissioned and provided by the Primary Care Trust (PCT) until 1 April 2011. This is now provided by private health provider. Healthcare staff are available 24 hours a day.
20. The Offender Health Division of a Healthcare NHS Trust took over provision of mental health services at New Hall on 1 December 2010. The mental health team are available during the day and there is an out-of-hours phone advice service available.

## **HM Inspectorate of Prisons (HMIP)**

21. HMIP last conducted an inspection of New Hall between 31 January and 1 February 2012. The Inspectorate noted that health services were not fully integrated into the prison meetings structure which led to misunderstandings. HMIP also considered that there should be a health promotion strategy and a systematic health promotion campaign through the prison.
22. In relation to mental health awareness, the Inspectorate noted that almost nine out of ten uniformed officers had been trained in raising awareness of how to help prisoners with mental health problems, which was regarded as an exceptionally high level of training.

## **Independent Monitoring Board (IMB)**

23. Each prison in England and Wales has an Independent Monitoring Board of unpaid volunteers from the local community, who monitor all aspects of prison life to help ensure that proper standards of care and decency are maintained. The most recently published report for New Hall covered the year to 28 February 2012.
24. In their report, the IMB made the following comments about Integrated Mental Health Services:

“The small team of nurses have been proactive in identifying and transferring residents who require hospital treatment to appropriate settings and have actively participated and supported in the ACCT process maintaining the safety of residents.

They are also working at improving the care planning process, delivering a proactive service as well as establishing a CPA framework based on national standards.”

### **Stockton Hall Hospital**

25. Stockton Hall provides secure mental health facilities and care for men and women with complex mental health needs. It provides integrated assessment, treatment and rehabilitation for patients within 23 medium secure, low secure and specialised rehabilitation units with 112 places.

### **Previous deaths at HMP&YOI New Hall**

26. Since 2008, there have been three deaths through natural causes including the woman's. There are no similarities between previous deaths and that of hers.

## KEY EVENTS

27. The woman was born in September 1986. She had a history of alcohol and drug abuse from an early age and had previously served a six month custodial sentence at New Hall in 2002.
28. The woman appeared at Crown court on 24 March 2007 charged with murder and was remanded to New Hall. Between April and December 2007 she displayed signs of a possible eating disorder. She complained she felt bloated, spent a lot of time in her cell exercising and was noted to have lost weight despite eating large amounts at meal times. Prison staff were concerned and referred her to the doctor on 3 July 2007.
29. The records show that a doctor saw the woman in July 2007 and identified a possible eating disorder. It was noted that she used the gym regularly. She requested laxatives daily. A nurse advised her on 3 October 2007 about their use and the risks involved. She said that she was happy to stop them and had not been using laxatives for weight loss.
30. On 3 December 2007, the woman was sentenced to life imprisonment for murder.
31. On 17 December, the woman had blood samples taken and the results were noted as normal, apart from her potassium levels which were extremely low at 2.1mmols per litre. (The lower normal range is 3.5mmols per litre). It is not clear from prison records what action was taken in respect of these findings.
32. On 17 January 2008, the woman collapsed and was attended by health care staff. She stopped breathing and cardiopulmonary resuscitation (CPR - a mix of chest compressions and rescue breaths to maintain oxygen flow around the body) was given together with oxygen. Paramedics attended and a defibrillator was used. She was taken by ambulance to hospital.
33. After extensive tests and assessments, it was confirmed that the woman had suffered a cardiac arrest, secondary to hypokalaemia (lower than normal amount of potassium in the blood). This condition was attributed to bulimia nervosa which had caused her blood serum potassium levels to drop. No evidence of structural damage to her heart was found. During her stay at hospital she continued to binge on food and vomit. She denied she had an eating disorder. Her potassium levels returned to normal and she was discharged back to New Hall on 11 February. A consultant cardiologist at hospital told the prison that he was concerned that she would continue with the bulimia and that staff should be vigilant for signs of self-induced vomiting and laxative abuse. He suggested that if there was any suspicion of bulimia, she should be closely observed in healthcare at the prison and that a forensic psychiatrist should be consulted.
34. Healthcare staff at the prison were advised to monitor the woman's potassium levels by taking weekly blood tests. On 13 February, she was seen by the mental health in-reach team (MHIRT) to provide her with psychiatric support

because of concerns that she was still suffering from bulimia. She admitted she had been making herself vomit before she had come to prison but that it had subsequently become worse. She also said that she wanted to use the gym to tone up.

35. The result of a blood sample taken on 13 February was considered normal, with her potassium level at 4.0 mmols. The woman did not attend for her blood test appointment on 20 February and therefore her next sample was not taken until 26 February. A prison doctor was concerned for her welfare. She was admitted to the healthcare unit at New Hall on 28 February where her blood test results were received and her potassium levels noted as very low at 2.9mmols. She was immediately transferred to the coronary care unit at hospital.
36. Throughout her second stay at hospital, the woman continued to binge and vomit. She was referred to a psychiatric hospital and examined by the Head of Psychology and the Medical Director. Both recommended her admission under Section 47/49 of the Mental Health Act 1983 (involuntary detention). She had described loss of control of eating, abuse of laxatives, excessive exercising, and concerns about her body image and preoccupation with food. She understood that she was in hospital because her vomiting had caused a low potassium level which had affected her heart. She did not know if she could stop her self-induced vomiting if she returned to prison. She was admitted to hospital on 14 April 2008.

### **Psychiatric Hospital April 2008 – June 2010**

37. The woman initially continued to binge and vomit at the hospital and as a result her potassium levels varied. She was prescribed spironolactone (a potassium sparing diuretic) to help maintain normal levels of potassium and occasionally an oral potassium supplement (Slow K) and received intensive counselling and psychotherapy for just over two years.
38. On 7 June 2010, a meeting between staff from the hospital and New Hall was held to discuss the woman's prospective return to New Hall following successful treatment of her eating disorder. The Medical Director reported that her eating disorder no longer needed to be treated in hospital, as she had responded to psychological treatment. She had received two years of intensive therapy and would require only support sessions on her return to prison.
39. The Medical Director explained to prison healthcare staff the protocol to be used to monitor the man's serum potassium and suggested that oral potassium (Slow K) should be given if her levels fell below 3.5mmols and that she should continue on small doses of spironolactone. He advised that she should not be prescribed laxatives or any other diuretics and should have regular blood tests. If she failed to attend for blood monitoring then she should be actively sought and if there was evidence of her potassium levels dropping appropriate action should be taken. He also advised the appointment of a named person for the integration of her care in the prison.

40. The Medical Director highlighted that the woman's eating disorder might return but she was now aware of the serious risk to her health. She said that she wished to go back to prison to serve her sentence and would be prepared to talk to staff and attend for her potassium levels to be checked. In a letter to the Medical Director in April 2010, a consultant cardiologist at the hospital explained:

“It is extremely important that there is similar monitoring of her potassium levels in New Hall Prison with careful observation of her behaviour. If potassium levels are allowed to fall below the normal range she is at risk of sudden death”

### **New Hall June 2010**

41. The woman returned to New Hall on 16 June 2010. Her reception health screen noted her previous cardiac arrest, recorded her weight as 10st 3lbs and noted that she was fit to attend the gym and fit for work. A primary care assessment was completed on 20 June 2010, in which it was noted that she had returned from Stockton Hall following treatment for bulimia and requested transitional support from a registered mental nurse (RMN) and the doctor. This noted that she felt she had her bulimia under control.
42. The care plan included weekly blood potassium checks, fortnightly appointments with the prison doctor and weekly psychiatrist appointments, with a weekly review by the nurse practitioner. It started within one day of her return to New Hall. However, her first psychiatric appointment was not until 26 July.
43. The woman's potassium levels remained within the normal range and did not drop below 3.5mmols. The entries in her medical record show she was still preoccupied with food and a desire to exercise daily, although she felt her eating disorder was under control and had a positive self image.
44. The woman applied to use the gym four times a week and also exercised in her cell. A routine questionnaire (PAR-Q- Pre Activity Readiness Questionnaire, which is also used in the community) should have been completed. This is a self-declaration form, used to assess whether a person has the medical/physical capability to carry out exercise safely. We were told one would have been completed but the prison was unable to evidence this. She had been assessed as fit for the gym by the reception nurse. An entry in her medical record, dated 2 July 2010, by a nurse indicated that an operational manager would brief staff about her excessive exercise in the past and if her potassium levels dropped, her access to the gym would be stopped. It is therefore apparent that some account was taken of her previous health problems, although it is not clear what the mechanism was to ensure that gym staff were made aware of any drop in her potassium levels.
45. At first the woman worked in one of the workshops on her return to New Hall. She received good reports from staff about her helpful attitude and positive

work ethic and went to the gym regularly every evening. In January and February 2011, her blood potassium began to rise above the normal level and her medication (spirinolactone) was stopped on 30 March. At this time she changed jobs and began work as a cleaner in the gym. Gym staff monitored the extent of her exercise.

46. Within four months, the woman became a gym orderly which involved assisting prison physical education officers with less able members of the gym and gave her more responsibility and involvement in group and individual exercise. The investigator was told that she was risk assessed by gym staff to carry out this role; however, the record of these risk assessments could not be found. A Physical Education Officer (PEI) explained she was aware she had an eating disorder and that her potassium levels were checked regularly. She was not aware of any other existing medical issues. She said the woman often stayed in the gym after her working day and at weekends to exercise.
47. The woman's blood potassium levels were monitored regularly between 28 April and 1 September 2011, they stayed within the normal limits, except on 22 June 2011, when her levels dropped to 3.4mmols, just below the range. There is no record of staff taking any action or following the protocol agreed with Stockton Hall, but she was tested again two weeks later and her potassium level was back within the normal range at 3.7mmols. Her blood was tested on two further occasions before her death and her potassium results were within the normal range at 4.0mmols.
48. On 8 August 2011, the woman injured her left ankle while playing football in the gym. An X-ray showed it was fractured. This restricted the type and amount of exercise she was able to do. At the same time she, although not a Muslim, decided to fast during Ramadan. This covered the month of August in 2011. She had sought advice from a fellow prisoner and the Muslim chaplain. The fast involves not eating or drinking between the hours of sunrise and sunset. Food provision packs had been put in place for registered and practising Muslims during Ramadan, but she was ineligible to receive one. The chaplain advised her against fasting on religious grounds. The chaplain was not aware that she had previously suffered from an eating disorder.
49. The investigator spoke to several prisoners, including Prisoner A, who explained she had been fasting for Ramadan and was aware the woman had also chosen to fast. She had discussed this with her and knew she was not a practising Muslim and therefore would be unable to have a special food provision pack. The prisoner said the woman was keeping food from mealtimes saving it for later in the day. She said that she was still attempting to exercise in her cell and had lost a lot of weight. She said she had given biscuits to the woman on the Friday before she died. Her prison and medical records do not indicate that staff had noticed that she had lost weight or that her weight was being monitored. It is not evident that she maintained a fast throughout Ramadan. Prisoner B, a friend of the woman's and a fellow gym orderly was a Muslim and observing the fast. She said that the woman only continued the fast for about the first week and a half, after which she had her period, when women are no longer expected to fast. She said the woman ate

normally after that and she told her not to feel guilty when she ate in front of her.

50. A registered mental health nurse (RMN) and senior practitioner was responsible for the woman's care from December 2010. She told our investigator that when she returned from Stockton Hall she looked much healthier, had put on weight and was aware her potassium levels would be monitored. As part of her care plan and to provide transitional support, her appointments were initially weekly. This was reduced to every two weeks and then eventually monthly at her request. She believed she was now in control of her eating habits and as long as her potassium levels were normal, she considered herself well. The RMN commented that she thought she was controlling her eating disorder by exercising in the gym, particularly when she had eaten a normal meal. She never disclosed a return to self-induced vomiting to anyone and the wing staff had not raised any concerns. The RMN spoke to wing and gym staff regularly to ensure they were kept updated. However she felt that she still had issues with food.

### **Events leading up to the woman's death**

51. On Friday 9 September, a PEI saw the woman and during their conversation she said she felt fit and well. On Sunday 11 September, she was working in the gym and took part in weight training and volleyball in the afternoon. She then distributed the physical education lists on the wings before returning to Poplar Wing. Prisoner C, the prisoner in the cell next to the woman's, told us that she saw her collect an abnormally large plateful of food from the servery and return to her cell. This was the last time the prisoner saw her.
52. Prisoner D, who lived in the other cell next to the woman, had known her since 2007. She was aware of her eating disorder and cardiac arrest in 2008. She said that her weight had dropped to below 7 stones before being admitted to Stockton Hall. She had noticed in the previous twelve months that she appeared to have problems with her food again. She said that on some days the woman would eat just a bowl of vegetables and then go straight to the gym to train. She also exercised in her cell.
53. The prisoner told the investigator that on the Sunday before the woman was found, prisoners were locked in their cells at 4.10pm. She spoke to her through the walls during television advertisement breaks and then for ten minutes after a programme had finished. She said she went to sleep at about 2.00am and at that time the woman's music and television had been turned off. She woke at 7.15am but did not hear any movement coming from her cell until her alarm clock sounded at 7.45 am. The alarm continued for about ten minutes which the prisoner said was unusual because she was usually up before her alarm.
54. Officer A worked on Poplar wing and began his shift at 6.30am on Monday. He began opening cell doors at about 8.20am. The first cell he unlocked was the woman's. He told our investigator that he saw her in bed and spoke to her but she did not reply. He went into the cell and tried to wake her but there

was still no response. Her quilt was covering her face so he pulled it back. He could see that her hands were clenched and she did not respond. He checked for a pulse but could not find one, she felt cold to the touch and rigid and he believed she had died. He called Officer B, who was unlocking cells on the opposite side of the wing. He went back into the cell and checked again for a pulse, but could find no sign of life. He then left the cell and pulled the door behind him and waited for healthcare staff to arrive.

55. Officer B had alerted an operational manager and other officers present on Poplar Wing including an officer who immediately called a code blue (an emergency code to signify someone is not breathing) over the radio. Two nurses were on Poplar Wing and responded to the call. At 8.28am Nurse A attended the cell and Nurse B collected the resuscitation equipment. Nurse A examined the woman and informed her colleague that she had died. Nurse B saw her lying on her back in bed, her skin was pale and her hands were clenched. As she was rigid they did not attempt cardiopulmonary resuscitation (CPR). At about 8.30am an ambulance was called. Paramedics arrived a short time later and carried out a heart trace on her; they pronounced her death at 8.54am.

### **Events following the woman's death**

56. An officer was appointed as prison family liaison officer and, together with an operational manager, went to the woman's mother's home later that morning. She was not at home. However they found her and the officer Shields operational manager broke the news of her daughter's death before taking her home. The woman's partner was serving a sentence at HMP Frankland and, the Governor told him that she had died.
57. The Governor issued a notice to prison staff and prisoners to inform them of the woman's death. A staff debrief was held on 12 September. Prisoners on Poplar Wing were taken to the chapel to be told about the death and were offered additional support. Prisoners on suicide and self-harm monitoring were checked in case they had been badly affected by the news.
58. A memorial service was held at the prison on 14 September, which the woman's family attended. They visited the prison and her cell on 15 September. Her property was returned to her mother and, in line with national guidance, financial assistance was offered towards the funeral.

### **Post-mortem Report**

59. A Home Office pathologist carried out the post-mortem examination. In his report, he stated that the woman's death was most likely the result of ischaemic heart disease caused by coronary artery atheroma (narrowing of the arteries) and that it was unlikely that an abnormality of potassium led to her death.
60. The pathologist wrote that one of the woman's main coronary arteries had become severely narrowed. This would have significantly reduced the blood

flow to her heart muscle, and put her at risk of sudden cardiac death at any time. He stated that the severity of her heart disease meant her unexpected death could occur at any time, not necessarily while exercising.

61. The pathologist noted that the woman had a previous history of amphetamine use and that the use of such drugs can damage the coronary arteries and cause severe atheroma in young people. He also indicated the cause could be genetic.
62. The pathologist discussed the possibility that abnormalities of potassium concentrations led to the woman's death, as this could also cause sudden cardiac death. However, he noted that her potassium levels had been closely monitored and the last reading had been taken eleven days before her death and was within normal range.

## ISSUES

63. It is evident from the pathologist's post-mortem report, that the woman had severe heart disease which led to her death. He is clear that her sudden unexpected death could have occurred at any time and was not likely to be related to low potassium levels.
64. We are satisfied that prison and healthcare staff could not have done anything to prevent the woman's death. However, the investigation has identified some areas for procedural improvement not directly related to the cause of her death.

### Clinical care

65. The clinical reviewer examined the woman's prison medical records and suggests that she was displaying signs of an eating disorder very early on in her time at New Hall (in 2007). She discusses issues about her care in 2007 and 2008 in her report, which the Head of Healthcare will wish to consider.
66. The clinical reviewer identifies that an 'exceptional number' of staff and healthcare professionals were involved in the woman's care after her return to New Hall and this highlights the efforts of the healthcare team to care for her effectively. However, she suggests that a lead should have been identified to coordinate her care package with documented multi-disciplinary team meetings (MDT), to ensure continuity of care. This is something that the Medical Director advised on her return to New Hall in June 2010.

**The Head of Healthcare should ensure that, when a prisoner requires complex multi-disciplinary care, a lead professional is identified to coordinate the care.**

67. The first reception screening process and assessment includes one section on mental health, which makes no reference to eating disorders. The clinical reviewer has made a recommendation, with which we agree, related to identifying women prisoners who may be at risk of an eating disorder at an earlier stage.

**The Governor and Head of Healthcare should ensure that the reception screening process and assessment enables earlier identification of women prisoners who may be at risk of an eating disorder.**

### The woman's use of the gym

68. The records show that on her return to New Hall in June 2010, the woman was regularly using the gym. She became a gym cleaner then a gym orderly. The RMN responsible for her care believed she used exercise to help manage her eating disorder.
69. As part of the routine application system to use the gym, a medical questionnaire form (PAR-Q) and gym induction should be completed. If any

health issues are identified on this form, the prisoner should attend healthcare to be assessed for their suitability for gym activities. Three of the questions on the form relate to heart conditions. The prison has been unable to provide a PAR-Q for the woman. We are therefore unable to clarify whether she declared any of her physical or mental health conditions. There is no record of her being referred to healthcare for assessment as fit to undertake gym activity, which we would have expected to see. While she was passed fit for gym in reception, and there was a reference to her gym activity in a note in her medical record of 2 July 2010, there is no clear documented record that both her eating disorder and her previous cardiac arrest were assessed in considering her fitness to attend the gym. There is no suggestion that her gym activity and exercising contributed to her death but we consider it important that clear records of assessments are kept.

**The Governor and Head of Healthcare should ensure that prisoners with long term health conditions who apply to use the gym are appropriately assessed and monitored.**

### **The woman's eating disorder**

70. The woman had a long-standing eating disorder, which has resulted in a cardiac arrest early in 2008 through low potassium levels. She spent time in a psychiatric hospital and came back to New Hall under an agreed protocol for the management of her eating disorder.
71. The records show that the woman had regular reviews with mental health staff. However, it is unclear how much information was shared between the mental health team, wing and gym staff. Wing and gym staff seemed to be unaware of the implications and management of eating disorders.
72. Although the woman was not a Muslim, she decided she wanted to fast for Ramadan, which was for the full month of August in 2011. As she was not a registered practising Muslim she was not provided with the special pack of food given to Muslim observants of the fast. She was advised not to fast by the Muslim chaplain, principally for spiritual reasons. It is not clear how long she fasted but the evidence of her co-worker, Prisoner B suggests this was less than two weeks. If so, her fast during the day would have ended before mid-August. When she observed a daytime fast it appears that she ate some food provided by other prisoners and food she had stored. There is no evidence that this affected her health in any way. Her potassium levels were checked during this time and were within the normal range.
73. Despite the woman's history, staff were not alert to some of the signs and triggers and did not seem to link her exercise and fasting to consider whether there was a wider problem. While we accept that there is no evidence that these factors led to her sudden death, we believe that staff would benefit from a wider understanding of the signs of an eating disorder and how women may attempt to manage it.

**The Governor and Head of Healthcare should ensure that staff are aware of the signs and symptoms of eating disorders and how to make a referral for help.**

## CONCLUSION

74. The woman was remanded to New Hall in March 2007 and sentenced to life imprisonment in December that year. She displayed signs of an eating disorder during her time on remand, and in January 2008 she suffered a cardiac arrest due to low potassium levels in her body. She was diagnosed with bulimia nervosa in hospital and was transferred to a psychiatric hospital for treatment. She remained there for just over two years before returning to New Hall.
75. On her return to New Hall a comprehensive care plan was put in place which ensured that her potassium levels were regularly monitored and there was regular mental health input. Staff noted that she appeared well and they believed she was in control of her eating disorder. She regularly used the gym and became a gym orderly. Although she was not a Muslim, she decided to observe Ramadan by fasting during daylight hours for some time in the month before her death. There is no evidence this affected her health. Wing and gym staff were aware of her eating disorder and previous heart problems, but did not appear to have a good understanding of eating disorders should be identified and monitored.
76. The woman was found dead in bed in September 2011. The pathologist stated that her sudden and unexpected death could have occurred at any time and was due to severe heart disease rather than associated with her previous eating disorder. While the investigation has found some areas for improvement at New Hall, we are satisfied that prison staff could not have done anything to prevent her death.

## **RECOMMENDATIONS (service response below)**

1. The Head of Healthcare should ensure that, when a prisoner requires complex multi-disciplinary care, a lead professional is identified to coordinate the care.

**The National Offender Management Service (NOMS) accepted this recommendation.**

2. The Governor and Head of Healthcare should ensure that the reception screening process and assessment enables earlier identification of women prisoners who may be at risk of an eating disorder.

**The National Offender Management Service (NOMS) accepted this recommendation with the following comments:**

“The reception screening process at the prison is regularly reviewed to ensure that all relevant medical history is asked when patients are newly received into the prison. The reception screening is also followed up with a secondary medical screen that looks more closely at vaccination history and family medical history. Mental health is covered within the reception screen and if staff have any concerns then the patient would be automatically referred for follow up by the mental health team. It was agreed that two questions relating to eating disorders would be added to the secondary reception health screen in order to try and capture/identify any women who either had an eating disorder or who were susceptible to this condition.”

3. The Governor and Head of Healthcare should ensure that prisoners with long term health conditions who apply to use the gym are appropriately assessed and monitored.

**The National Offender Management Service (NOMS) accepted this recommendation with the following comments:**

“Where applications are put in for the gym (including for Fridays and weekends) and the PAR Q fails then this will be immediately passed back to healthcare for further review. It was acknowledged that due to capacity within healthcare not all referrals to the gym could be passed through healthcare. Any women who are picked up on reception as having a heart problem / DVT issues would automatically be passed to healthcare.

There will also be raised awareness on the wings on the importance of disclosing medical conditions. In some cases it was acknowledged that patients were not disclosing all medical information to healthcare or the gym as they wrongly thought that this would stop them using the gym altogether.”

4. The Governor and Head of Healthcare should ensure that staff are aware of the signs and symptoms of eating disorders and how to make a referral for help.

**The National Offender Management Service (NOMS) accepted this recommendation with the following comments:**

“An ongoing programme is already underway within HMP & YOI New Hall for mental health training. The Healthcare NHS Trust who are leading in this area are offering mental health awareness training to all staff groups on site (i.e. prison officers, governors and other healthcare professionals). A register is also kept for staff who attend these sessions.

A local Notice to Staff will also be distributed to all staff in order to raise further awareness (especially for wing based staff) who are more likely to see suspicious behaviour in regards to food habits.”