A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

Investigation into the death of death of a woman at HMP & YOI New Hall in November 2010

Our Vision

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

This is the report of an investigation into the death of a prisoner at HMP & Young Offender Institution (YOI) New Hall. The woman died in her cell on 26 November 2010. She was 49 years old. The cause of death was a cerebral aneurysm. I offer my sympathy and condolences to the woman's family and all those affected by her loss.

The investigation was carried out by an investigator. A clinical review of the woman's medical care was carried out by a clinical reviewer on behalf of Wakefield District Primary Care Trust. The Governor and staff of New Hall gave their full co-operation during the investigation. I apologise for the delay in issuing this report.

The woman was remanded into custody in August 2008. Soon after her arrival at the prison, she reported to staff that she was experiencing headaches. She was treated initially by prison healthcare staff, however her headaches persisted and she was referred to a local hospital for a brain scan. The scan showed no specific abnormalities.

Throughout the woman's time at New Hall, her headaches continued. Healthcare staff regularly monitored her for this condition as well as other pre-existing ailments up until her death. Unfortunately, the nature of cerebral aneurysms means that they can occur with no warning and the woman was found dead in her cell in the early hours of the morning.

I am satisfied that staff at New Hall managed the woman's symptoms and illnesses well and could not have foreseen her death. The investigation has found some scope for improvement in the management of the health of long term prisoners and the maintenance of next of kin records. I make two recommendations relating to these matters.

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.

Nigel Newcomen CBE
Prisons and Probation Ombudsman **August 2012**

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SUMMARY

1. The woman was remanded into custody at HMP New Hall in August 2008. On arrival at the prison, reception staff assessed her as being at risk of self-harm and put in place monitoring under the suicide prevention and self-harm management procedures for just over two weeks. (She was subsequently monitored under these provisions for a few days in mid-January 2009, around the time she was sentenced.)

2. Prior to the woman's remand into custody, she had been receiving treatment for a gastric condition and this continued at New Hall. She had also been referred to alcohol counselling services by her doctor in the community and, having been appropriately assessed by healthcare staff, the woman began a medically supervised alcohol withdrawal programme.

3. In September, a few weeks after she went to New Hall, the woman had an appointment with the prison doctor during which she complained of headaches. As the initial treatment did not effect an improvement, an emergency referral was made to a neurologist. The woman was referred for a brain scan which took place on 27 October. The scan highlighted some changes in the blood supply to her brain but otherwise revealed no abnormalities.

4. Over the next two years, the woman continued to experience headaches intermittently. During those periods, she was regularly seen by the prison doctors. They tried a number of different medications, of varying doses, in their attempts to find effective pain management for her. In September 2010, the woman was given a prescription for amitriptyline, with a plan to review her medication if this did not work.

5. On the morning of 26 November, staff found the woman collapsed in her cell during the morning check of prisoners. Prison healthcare staff attended promptly but they did not attempt to resuscitate her as it was clear that she had been dead for some time. Staff called the emergency services and the paramedics who attended pronounced the woman dead at 6.31am. The inquest subsequently determined that the cause of her death was a cerebral aneurysm.

6. As the woman' next of kin, her brother, lived a long way from the prison, the Governor arranged for the police in her brother's local area to break the news to him. A debrief meeting was held and staff involved in the emergency were offered support.

7. The investigation concluded that the woman was given appropriate treatment for her health conditions at New Hall and that her death was unexpected. However, there is a need to ensure that long term prisoners with continuing medical needs are managed appropriately and that next of kin details are accurate. Recommendations have been made relating to both those matters.

THE INVESTIGATION PROCESS

8. The investigation into the woman's death was carried out by a senior investigator. The investigator opened the investigation on 30 November 2010, when he visited HMP New Hall. He met one of the operational managers, the chaplain and the prison family liaison officer.

9. Notices were issued around the prison announcing the investigation to staff and prisoners. The notices invited them to make themselves known to the investigator if they wished to contribute to the investigation. No prisoners came forward.

10. The investigator was provided with relevant documentation pertaining to the woman's time at HMP New Hall. This included her main prison record, medical records and statements made by staff at the time of her death. The investigator also visited Poplar wing and the woman's cell.

11. Wakefield District PCT appointed an RGN to carry out a clinical review of the medical care the woman received during her time at HMP New Hall. We are grateful for the clinical reviewer's contribution to this report.

12. The investigator also contacted HM Coroner for West Yorkshire Eastern District to inform him of the scope and nature of the investigation and to request a copy of the post mortem report. The Coroner will receive a copy of the report to assist him in his enquiries. The investigator interviewed five medical staff from HMP New Hall in the presence of the clinical reviewer. He also interviewed seven prison staff. All of the interviews were recorded and are attached as annexes to this report.

13. The family liaison officer, contacted the woman's nominated next of kin, her brother. She explained the purpose of the investigation and gave them an opportunity for the family to raise any issues about the care the woman received.

14. The woman's brother told the family liaison officer that he considered more should have been done to investigate the cause of the woman's headaches. He also commented that he believed she did not receive the medical care she needed from the start of her time in prison. He was also unhappy about some of the liaison with prison staff in the lead up to the woman's funeral. The woman's family raised further concerns after receiving the draft report that are outlined in paragraphs 87 and 88.

15. It is hoped that the findings of the investigation address the family's issues and help them to better understand the circumstances of the woman's death. The delay in issuing this report is regretted. This was due to workload pressures within this office.

HMP and YOI NEW HALL

16. HMP and YOI (Young Offender Institution) New Hall is a closed local training prison. It opened in 1933 as one of the first open prisons for men however in 1987 it became part of the women's estate. New Hall can house up to 447 women, young adults and juvenile girls. It also has a mother and baby unit.

17. Prison Service Order (PSO) 0900 Categorisation and Allocation explains the reason for categorising prisoners:

 "*Prisoners must be categorised objectively according to the likelihood that they will seek to escape and the risk that they would pose should they do so.*"

18. Women prisoners are categorised into four categories. They are:

 "Restricted Status" which is similar to category A for men and means that escape would dangerous for the community.

 "Closed" for prisoners who are not trusted to escape.

 "Semi Open" for those prisoners unlikely to escape.

 "Open" for those prisoners who can be trusted to stay within the prison.

19. The woman had been sentenced to life imprisonment and was categorised as restricted. This means she was required to serve her sentence in closed conditions.

Healthcare at HMP New Hall

20. Healthcare at New Hall is commissioned by the Wakefield District Primary Care Trust, who also provide primary care and substance misuse services. Mental Health services are provided by the Southwest Yorkshire Mental Health Trust. The prison has an inpatient facility consisting of 12 beds, including one cell for disabled prisoners, all in single rooms. Full-time prison doctors are employed. They hold clinics during the morning and on two afternoons a week from Monday to Friday and on Saturday mornings. Out of hours care is provided by "Local Care Direct".

Her Majesty's Chief Inspector of Prisons

21. Prisons in England and Wales are subject to inspection by HM Chief Inspector of Prisons. Following the last full inspection of the prison in November 2008, the Chief Inspector reported that New Hall held a "needy and challenging population" but was "a reasonably safe and purposeful prison".

22. The inspection reported on a number of concerns that are relevant to this investigation:

- a significant number of the women arriving at New Hall had serious substance abuse mental health and self harm issues;
- anti-bullying and suicide prevention arrangements needed some improvement;
- there was a particular need for better support for the very high numbers of women reporting alcohol related problems;
- work and skills provision was sufficient.

23. The inspection team also found that health services were stretched with an over-reliance on agency staff. However, they found primary care to be satisfactory, albeit that women waited too long for routine appointments. Mental health services were considered to be generally good, however the social care needs of some women managed on the wings were not well met.

Independent Monitoring Board

24. All prisons in England and Wales have an Independent Monitoring Board (IMB). The IMB is made up of local people who are appointed by the Secretary of State for Justice to serve on the Board. All members of the Board have full access to the prison and prisoners. They deal with a range of issues including prisoner complaints, the prison regime, standard of healthcare and security.

25. Each IMB is required to publish an annual report. In their most recent report, published in February 2010, the IMB reported that the healthcare team at New Hall worked extremely well with difficult and challenging "residents". The Board also commented that healthcare staff maintain their professionalism, high standards of care and treat the residents with courtesy, kindness and dignity.

Assessment, Care in Custody and Teamwork

26. Assessment, Care in Custody and Teamwork (ACCT) was introduced in all prisons to monitor and support prisoners assessed as at risk of suicide or self-harm. Once placed on ACCT, the prisoner is subject to regular case reviews that will direct observations/conversations to be carried out at intervals determined by their perceived level of risk. The observations continue during the day and the night.

Cell Sharing Risk Assessment

27. The Cell Sharing Risk Assessment (CSRA) is designed to assess the risks posed by an individual to other prisoners. This includes taking into account the context of any previous violence or mental health issues. The assessment takes place before a prisoner spends their first night in custody (with the exception of open prisons) and triggers a plan to minimise risk for prisoners. The assessment identifies risk as either raised or low, and is reviewed at regular intervals. The woman's CSRA was reviewed every three months.

Previous deaths at New Hall

28. The woman's death was the eighth to have occurred at New Hall since April 2004 when this office began investigating all deaths in prison custody in England and Wales. The woman's death is the third natural causes death to be investigated at New Hall. There are no similarities between the woman's death and previous deaths New Hall.

KEY EVENTS

August 2008 to December 2009

29. The woman was arrested and charged with the murder of her partner in August 2008. She was remanded into custody at Sheffield Crown Court on 12 August and taken to New Hall.

30. The clinical reviewer reviewed the records from the woman's general practitioner (GP). She noted that prior to her remand in custody, the woman had been dependent on alcohol for at least four years. She had also been diagnosed with gastritis (inflammation of the lining of the stomach) which was being managed by her doctor. Prior to her arrest, she had been referred to Barnsley Alcohol and Drug services as it had become clear that her use of alcohol had begun to impact on her relationships with others.

31. During her reception at New Hall, the woman was interviewed a number of times by prison staff who assessed her physical and mental well being. They noted that she had bruises to her face and a large lump on her head. Staff thought she had sustained these injuries a few days before her arrest, when she had been under the influence of alcohol. She complained of head and neck pain, however this was attributed to the incident in which she had been injured. The woman's GP records showed she had been treated for consistently high blood pressure in the previous 3 months. The prison doctor who saw her on reception prescribed chlordiazepoxide, (cdz; a drug used to treat the effects of alcohol withdrawal) and omeprazole (for inflammation of the stomach). The woman also mentioned to reception staff that she had a history of thinking about harming herself.

32. At her Cell Sharing Risk Assessment (CSRA) interview, the woman told an SO that she abused alcohol and had previously harmed herself. The SO assessed her as at being risk of self-harm and put in place the suicide prevention and self-harm management procedures. As part of the procedures, the senior officer opened an ACCT document to record the detail of the monitoring and action plans. The woman was then assessed by healthcare staff who also recorded on the CSRA that she felt low in mood and was being monitored under the suicide and self-harm procedures. The SO recommended that the woman be checked by officers every thirty minutes. In view of the nature of her charges, she was assessed as being at high risk of harming other prisoners and therefore unsuitable to share a cell. Accordingly, she was given a single cell.

33. The woman had also told medical staff, at reception, that she wanted to be with her partner and that she felt suicidal. A doctor assessed her and wrote in the medical record that she did not appear to be clinically depressed. Staff told the woman that they would allow her to have a telephone call to the Samaritans and provide access to prison Listeners (prisoners who are trained by the Samaritans to offer emotional support 24 hours a day to fellow prisoners in distress). They also ensured that the woman did not have any medication in her cell.

34. The following day, 13 August at 2.00pm, an SO and an officer held an ACCT review meeting. The woman told them that she could not cope with a headache and, at the time, exhibited behaviour described by the officers as "bizarre". They recorded in the ACCT file that she was "holding her head and laughing at things." Healthcare staff gave her pain killers for her headache.

35. The woman gradually settled into prison life with no further evidence of feelings of harming herself. The ACCT monitoring stopped on 27 August. During the closure meeting, the officer interviewed the woman and wrote that she "remains in a positive mood…and will speak to staff if she feels low…is aware of the Listener scheme and availability of the Samaritans phone."

36. On the same day the monitoring ended, the woman saw the doctor regarding her headaches. The doctor noted that they were at the front of her head; were worse at the end of the day, but there was no nausea and her eyesight was not affected. He diagnosed muscular headaches and advised that she stop taking paracetamol and replace it with carbamezipine (a drug which stabilises electrical activity in the brain). The SO carried out the ACCT post closure review on 2 September.

37. On 12 September, the woman was reviewed by a doctor. She told him she had been suffering with headaches for two months and that they were no better since she had been taking carbamazepine. The doctor prescribed ramipril (a drug used to treat high blood pressure).

38. There was no significant improvement in the woman's headaches and an urgent referral was made to a neurologist. She had a brain scan 27 October which highlighted some ischaemic changes (changes in the blood supply) in her brain and an old infarct (dead tissue) but no specific abnormalities. The woman's blood pressure also returned to normal.

39. In November, the woman had a suspected deep vein thrombosis (blood clot) and was given anti coagulant therapy (which prevents clotting of the blood). This was stopped in December when further investigation showed her symptoms had improved.

40. On 12 January 2009, the day before the woman was due to be sentenced for murder, the officer again placed her on monitoring under the suicide and self-harm provisions. This action was taken after other prisoners alerted staff to comments she made that she intended to kill herself if she received a sentence of more than five years.

41. The woman was put on irregular, intermittent watches, with 15 minute intervals between each check. She was fully involved in the ACCT monitoring process. The following day, 13 January, just before going to court, she asked for the ACCT monitoring to be stopped because the comment she had made about killing herself was flippant and she had no thoughts of harming herself. Officers responded by telling her that closure of the ACCT process would be dependent on further assessment and review. Later that day, the woman was

sentenced to life imprisonment with a tariff of 13 years. (The tariff is the number of years she would need to serve before she could apply for release on licence.)

42. Escort staff and prison officers described the woman as very talkative, and appreciative of the treatment she received at court. An officer made an entry in the ACCT record in which the woman is quoted as saying that she would not be here at 60 when she was due for release. As a result of this statement, staff increased their observations on her. She was assessed later that day by a Registered Mental Nurse (RMN), who wrote in the ACCT document that the woman was very bright in her mood, denied any thoughts of self-harm and could not understand why everyone was making a fuss. The nurse ended her entry by stating she had no concerns.

43. On 14 January, the officer interviewed the woman and decided that observations could be reduced with a view to closing the ACCT process. At 11.15am on the same day, the SO and an officer interviewed her. She told the officers that she had no thoughts of self-harm or suicide and was confident she would be able to approach staff if she needed to. The SO decided to stop the ACCT monitoring. This decision was reviewed on 21 January, by an operational manager, who wrote that the woman had accepted her sentence and commented that she had a lot of support from other prisoners and staff which had helped her a lot.

44. On 17 February, the woman had an appointment with a doctor regarding hot flushes, headaches and waking at night. She told the doctor that she had experienced these symptoms for over three years. The doctor prescribed clonidine, a medication to treat high blood pressure, on a trial basis for two weeks. However, this treatment was stopped after a GP consultation on 3 March as it had no effect. Tests for liver function and hepatitis were also requested. The results of both were negative.

45. The woman’s headaches continued and she was given ibuprofen and paracetamol. The doctor reviewed her in June and suggested that her headaches might be caused by tension. The doctor prescribed a course of propanolol (a drug used to treat high blood pressure) on a trial basis. The woman had been prescribed propanolol in the community and found it to be helpful. This medication was stopped in August when the woman reported that she felt her headaches were due to “work related stress” (The woman was employed in the prison workshops). She was advised to take ibuprofen as required and referred to the optician. A short time later, an optometrist examined her but found nothing untoward. (Optometrists are specialists who are trained to detect diseases of the eye and identify other diseases such as diabetes.)

46. In September, the woman was prescribed amytriptyline (an anti depressant) which led to significant improvements in her mood. She saw the optometrist again in November and there was nothing to cause concern.

47. On 5 November, the woman told an officer that she was anxious to hear from her son who at that time was also a serving prisoner. Two weeks later, on 20 November, the prison facilitated a video link to her son, which appears to have settled her concerns.

48. During November and December, the woman attended appointments with the prison GP about her continuing symptoms of flushes and headaches. The GP increased the dosage of her medication.

2010

49. On 23 March, the woman was reported under the disciplinary procedures for her failure to provide a urine specimen for a mandatory drugs test (MDT). The officer wrote on her case note history (a prison document where staff record observations about individual prisoners) that the woman was: "devastated" and low in mood as she expected the outcome to be cellular confinement in the segregation unit. (This is a punishment imposed on prisoners for a breach of prison rules. They are isolated from other prisoners and have privileges removed.) At the disciplinary hearing the following day, the woman pleaded guilty. The penalty was 14 days cellular confinement and she was segregated from other prisoners. During her time in the segregation unit, she was seen regularly by a nurse from healthcare and made no complaints regarding further headaches. Healthcare staff commented that her headaches appeared to be under control.

50. During her sentence, the woman regularly worked in the prison workshops under the supervision of workshop instructor. The investigator interviewed the workshop instructor, who told him that the woman acquired a lot of sewing abilities in the workshop and was a very good worker. She added that the woman made a significant contribution to New Hall winning a prize in the Butler Trust award. (The Butler Trust award is an annual competition which recognises and celebrates outstanding practice by people working in prisons and other parts on the criminal justice system.) The workshop instructor told the investigator that the award, the Elton Trophy, was dedicated posthumously to the woman.

51. A sentence review meeting was held on 24 September. The review considered the woman's progression on her sentence and the possibility of a move to HMP Send to undertake a course.

52. The prison doctor reviewed the woman on 27 September. She told him she was happy on amitriptyline but that her headaches had recurred. The dose was increased to 100 mgs daily and she was encouraged to return to see the doctor if her headaches did not improve.

53. The woman's lifer officer, discussed the possible move to Send with the woman, on 29 September. (The lifer officer is an officer trained to deal with the specific needs of life-sentenced prisoners.) She told the officer that she did not want to move to Send, but would prefer a move to HMP Foston Hall instead. A plan was made for the officer and an operational manager to meet

the woman to ensure she was clear about the options open to her during her sentence. They held a meeting on 4 October in which it was agreed that she would transfer to Foston Hall when a place became available. This was followed up on 19 November, but Foston Hall still had no space.

54. At 10.00pm on 25 November, an Operational Support Grade (OSG) who was on night duty, spoke to the woman through the cell door and wished her goodnight. The OSG wrote in her statement to the Governor that the woman replied, also wishing her goodnight. (OSGs are prison staff who have little direct supervisory contact with prisoners. They are used in a support capacity to carry out tasks such as escorting prison visitors and patrols when prisoners are locked in their cell.)

Events of 26 November

55. At approximately 6.00am, the OSG was carrying out cell checks on Poplar Wing at the end of her night shift. Her duties required her to check each cell and account for all prisoners on the wing, prior to handing over to the day staff coming on duty. This is known as the roll check.

56. The OSG went to the woman's cell and looked through the observation window in the cell door. She told the investigator in interview that the cell was in darkness. She explained that this was unusual as the woman was an early riser who was often out of bed with the lights on. The OSG put the cell light on and saw that the bed was empty. She looked further into the cell and saw the woman lying on the floor near to the cell toilet. The OSG asked her colleague to call for assistance on her radio.

57. In interview with the investigator, the OSG said she was further down the wing checking cells, when she was asked to call for assistance over her radio. She was not aware of exactly why her colleague asked her to call for help, however she did so and started to make her way to the woman's cell. During the night, radios in the prison are on "talk through" meaning all staff with radios will hear emergency calls.

58. The senior staff member on duty that night the SO was with an officer and heard the call for urgent assistance over the radio. She told the investigator that the nurse had just walked past her and she was able to shout to him to follow her and the officer to Poplar wing. The nurse had also heard the emergency call as "Hotel 1 to attend Poplar wing urgent assistance required." Hotel 1 was a nurse. She went to the wing office to pick up a bag containing emergency equipment, including a defibrillator (a machine used to deliver therapeutic doses of electrical energy to the heart). She joined a nurse as he made his way to the wing. The SO estimated that it took no more than two minutes to get to the woman's cell. (Hotel 1 is the radio call sign for healthcare in the prison)

59. The OSG broke the seal to the night keys and entered the cell. She went to the woman and immediately checked for a ligature. As there was no ligature

she checked for a pulse. At this time, the officer and nurse arrived. (Night keys are sealed keys issued to night duty OSGs for use in emergencies only.)

60. In his statement, the nurse wrote that he arrived at the wing at 6.02am and went straight to the cell. He described the woman as slumped on the floor with her head also "slumped forwards." He checked twice for a pulse on her neck without success. He also checked her left wrist, again with no response. The nurse then arrived at the woman's cell.

61. In interview with the investigator and the clinical reviewer, the nurse described the woman's position as unusual and thought that it looked as though she had collapsed whilst standing up after using the toilet. He checked for ligatures and attempted to check her airway but had great difficulty opening her mouth. A nurse assisted a second nurse and, in her statement to the Governor, wrote that she thought the woman looked as though she had been dead for some time. The nurse said he knew that cardio pulmonary resuscitation (CPR) would not have been useful and that the presence of rigor mortis made moving the woman impossible. The defibrillator was not applied to the woman

62. The SO remained outside the cell and contacted the duty governor to inform her that the woman had died. Paramedics arrived at the prison gates at 6.24am and were escorted to the wing, arriving at 6.27am. They pronounced the woman dead at 6.31am. The nurse told the investigator that the attending paramedics also believed the woman had been dead for some time.

63. An operational manager held a hot debrief at 7.00am. (This is a meeting for staff involved in serious incidents to discuss issues and any immediate lessons learned.) All staff involved were present.

64. At 10.00am, the operational manager instructed an Executive Officer to contact the offender manager responsible for the woman's son to inform her of the woman's death. The message was then passed to the manager of her son's housing project. Her son's support workers were told and they, in turn, told him that his mother had died.

65. An SO was appointed as the prison's family liaison officer (FLO). She told the investigator that there was a delay in contacting the woman's nominated next of kin, her stepbrother. She said that when she arrived to begin her family liaison work she was handed a piece of paper with two names on it. One was a friend of the woman, the other, her son. The family liaison officer then decided to check the woman's full prison record and, in doing so, found her preferred next of kin's details. This was her stepbrother, who lived in Buckinghamshire. The family liaison officer reported this new development to the operational manager who was managing the prison's response to the woman's death. She told the investigator that this information was passed to the Governor of New Hall.

66. The Governor of New Hall decided that Buckinghamshire was too far away from the prison to send staff to inform the woman's stepbrother of her death.

In these circumstances, it is usual to contact a local prison and ask staff there to visit family members to inform them of a death. However, the Governor took the decision to contact the local police and ask them to visit the woman's stepbrother to break the news of her death.

67. At midday, the police liaison officer at New Hall telephoned Thames Valley Police and requested a home visit to be made to inform the woman's brother. The family liaison officer was due to go off duty at midday but stayed on into the afternoon to assist with the family liaison. When she left the prison for the weekend, the family liaison role was passed to another operational manager who knew the woman well, having previously managed her wing.

68. The operational manager told the investigator that the woman's son telephoned him in a very distressed state asking for information about his mother. At that time, the woman's brother had not been informed. He advised the woman's son he would call him back after his uncle had been informed to answer his questions. Her son accepted this but asked whether his mother had suffered. The operational manager told the investigator that he had been presented with a moral dilemma and decided to say "no".

69. The operational manager said that approximately 20 to 25 minutes later he was also contacted by the woman's ex-husband. He explained that he was unable to release information at that time as the woman's next of kin had not been informed. He explained that it was a difficult call to deal with and described the caller as bordering on abusive.

70. At about 4.00pm, the woman's brother contacted the prison. The operational manager passed all the necessary details on and offered to call the woman's son to explain what had happened. This was mutually agreed and the operational manager did so over that weekend. The operational manager had further contact with both the woman's son and brother.

71. The Coroner's officer had difficulty contacting the next of kin and therefore contacted the family liaison officer. She was asked to telephone the woman's brother and inform him that the pathologist had removed the woman's brain to ascertain the cause of death. The Coroner's officer also asked her to inform the family of the options open to them regarding this new development and the arrangements for the funeral. The family liaison officer contacted the woman's brother the same day and told him about the request from the Coroner's officer.

72. Staff and prisoners were notified of the woman's death both by way of notices around the prison and in person. The staff directly involved were also offered the support of the care team (prison staff trained to offer counselling and support following serious incidents).

73. The inquest into the woman's death opened on 3 December. The post mortem report recorded the cause of death as a subdural haematoma (bleeding on the brain) and a cerebal aneurysm. (An aneurysm is a weak

area in the wall of a blood vessel that causes the blood vessel to bulge or balloon out.)

74. New Hall prison made a contribution to the cost of the woman's funeral and a number of staff attended.

75. An operational debrief meeting about the woman's death was held at the prison on 9 December, chaired by an operational manager. The purpose of the meeting was to take forward the issues raised at the hot debrief held on the day the woman died and consider additional information which may have come to light. Staff discussed many issues, including the following, which are relevant to this investigation.

- Informing the next of kin.
- Updating prisoner records.
- Reviewing the contingency plans for emergencies.
- Staff actions at the scene of the emergency
- The role of the family liaison officer

ISSUES

Clinical care

Treatment of the woman's headaches and neurological investigations

76. During her imprisonment the woman's experienced severe headaches for which she was appropriately treated by medical staff. She also had periods when she had no headaches and interviews with prison discipline staff highlighted that most were unaware that she suffered from headaches and she was described as looking well and that her health appeared good. The woman also experienced menopausal symptoms, such as hot flushes.

77. A few weeks after her arrival at New Hall, staff made an urgent referral for the woman to see a consultant neurologist. A brain scan taken by the specialist showed no evidence of bleeding or tumour and revealed no specific abnormalities. The consultant advised that her symptoms were suggestive of muscle tension type headaches. The brain scan report also questioned whether there were any vascular risk factors. However, the results of the report do not appear to have been checked by a doctor before being entered on the computerised medical records system, so this question was not addressed.

78. The investigator and clinical reviewer explored the procedures for reviewing medical reports from external doctors. The doctors at New Hall, who work on a sessional basis, were aware of deficiencies in the system. They explained that, formerly, if a GP left the prison, there was no provision for their patients to be allocated to another named doctor. Also, correspondence from outside hospitals was placed in a generic in-tray and dealt with ad hoc by whoever was on duty, with some left for specific doctors. The doctors were aware this was a problem. They were concerned that reports and letters from hospitals and other outside health agencies were not being seen and that some were possibly going missing. The doctor told the investigator and clinical reviewer that the problem has now been addressed and robust systems are now in place to ensure all letters and reports are authorised by a doctor before being entered on the medical record system. In light of the recent improvements, no recommendation has been made on this point.

79. No specific doctor was responsible for overseeing the woman's medical care at New Hall. Whilst the nature of prison healthcare would make this difficult, it should be achievable for those prisoners serving life sentences, particularly those with chronic conditions. A named doctor would be able to oversee the care delivered and patients with on-going medical needs could be managed in a more holistic way. We therefore endorse and recast the clinical reviewer's recommendation regarding the weaknesses highlighted in the general management of prisoners' care;

    The head of healthcare should revise the protocol for clinical management of long term prisoners with ongoing medical needs to ensure consistent oversight and review of their care.

80. The woman's headaches were largely relieved by the prescription of painkillers. Whilst she was assessed and reviewed by doctors regularly, the records show that neurological examinations were carried out on only two occasions. (She was also given antidepressants and medication for high blood pressure.) The investigator and clinical reviewer asked whether the time lapse before a further referral was reasonable. The doctor suggested during his interview that re-referral to the consultant neurologist might have been considered if the changes made to the woman's medication in the weeks before she died had no effect.

81. The clinical reviewer sought the opinion of a general practitioner who does not work at the prison, about the care and treatment of the woman's headaches. The doctor's view was that the management of the woman by the prison healthcare department was equivalent to the care she would have expected to receive in the community. Accordingly no recommendation is made regarding the woman's treatment.

Suicide prevention and self-harm management procedures

82. During the woman's time at New Hall, she had periods of low mood during which staff provided additional monitoring under the suicide prevention and self-harm management procedures. Although this had no bearing on the health condition which led to her death, the investigator examined how the process was managed and reviewed the documentation.

83. The safer custody team at HMP New Hall manage all suicide prevention monitoring. We are satisfied that the processes in place for the woman in August 2008 and January 2009 were well managed and she was fully involved in review meetings held to discuss her progress. Observations took place as required and were checked by managers. There is also good evidence of staff engaging with the woman and helping her through a difficult time**.**

Breaking the news of the woman death to her family

84. It is unfortunate that the woman's son was informed of his mother's death by his housing support workers. This appears to have happened because of confusion as to who was the nominated next of kin. The family liaison officer subsequently found the woman's records with her brother's name and address.

85. As stated earlier in this report, the problems in notifying the woman's family were identified during the operational debrief held on 9 December 2010. The prison intended to take this forward as a learning and action point from the debrief. Nonetheless, in the absence of formal evidence that a process for

reviewing prisoners' records to record correct next of kin has been established, we make the following recommendation.

The Governor should ensure that the next of kin details of all prisoners are correct, in line with Prison Service Order 2710.

Liaison with the woman's family

86. The woman's brother told the family liaison officer that he was not happy with some of the comments made to him by the prison liaison governor. In his interview with the investigator, the prison liaison governor acknowledged that there had been a difficult conversation between him and a family member and he had not been able to answer all their questions about procedures. However, he said that he thought relationships had been good throughout his dealings with the woman's family. He said that he shook hands with family members at the funeral and thought that this was indicative of the cordial relationship that had developed between the family and the prison.

87. The woman's family received a copy of the draft report. As well as pointing out factual inaccuracies the family made the following comments. They remain concerned about the missing paperwork and lack of communication between the hospital and the prison staff. The family feel there was a missed opportunity regarding the IMR scan. The woman's brother is concerned about the attitude of nursing staff and believes the standard of treatment she received reflected the fact that she was a prisoner.

88. The woman's family commented that having read the report they remain unhappy about how they were handled after the death of the woman by some members of the prison staff. They also said that the woman kept a diary every day for years, where she mentioned her headaches. However in the last few months she stopped writing in the diary which they thought unusual and a matter of concern. The family would also like to pass on their thanks to the woman's art teacher for her kindness.

CONCLUSION

89. The woman was remanded into custody having been charged with the murder of her partner. She initially experienced difficulties in settling into the prison and her behaviour caused staff to be seriously concerned about her potential to harm herself. The monitoring of the woman's risk in this regard was successfully managed by prison staff. It is also clear, from the investigation, that she was well liked by uniform and instructional staff.

90. Once she settled, the woman worked hard in the prison workshop and made a significant contribution to the success of the work undertaken there. The dedication of a Butler Trust Award to her, posthumously, is good evidence of this relationship.

91. The woman's reported headaches over a long period. They were monitored and treated by both prison doctors and specialists at external hospitals. However, despite the attentions of medical staff this condition did not improve.

92. Just over two years after her imprisonment, the woman suddenly died. The subsequent post mortem determined that the cause of death was from a cerebral aneurysm. Aneurysms can occur without warning. Although headaches can be a symptom, previous tests had found nothing to suggest there was any pressure inside her skull which would have indicated a swelling in the brain. In the light of this, it seems that staff at New Hall could have done nothing to prevent her death.

93. The clinical reviewer concluded that the woman's treatment was the equivalent of what she would expect to have received in the community and that her death was "unpreventable". However, she considered there was scope for improvement in some of the systems and processes within the healthcare centre and this is reflected in clinical recommendations in her report. The clinical reviewer's view that there should be more consistent oversight of the care of long term prisoners is endorsed in this report. An additional recommendation has been made regarding the need to update the details of prisoners' next of kin.

RECOMMENDATIONS

1. The head of healthcare should revise the protocol for clinical management of long term prisoners with ongoing medical needs to ensure consistent oversight and review of their care.

   The National Offender Management Service accepted the recommendation and said:

   "Discussed with Spectrum – Primary Health Service Provider. They are to produce a protocol for long term case management to incorporate consistent oversight of clinical arrangements. To be progressed by Matron and (Chief Nurse / Head of Operations)."

2. The Governor should ensure that the next of kin details of all prisoners are correct, in line with Prison Service Order 2710.

   The National Offender Management Service accepted the recommendation and said:

   "A revised system for residents to advise their offender supervisor of any change to their next of kin details was implemented in 2010. This system … continues to operate effectively. However, a notice to Residents has been issued to remind residents of the procedures."