

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Ms Joanna Daly, a prisoner at HMP New Hall, on 2 June 2019

A report by the Prisons and Probation Ombudsman

Our Vision

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

Our Values

We are:

Impartial: *we do not take sides*

Respectful: *we are considerate and courteous*

Inclusive: *we value diversity*

Dedicated: *we are determined and focused*

Fair: *we are honest and act with integrity*



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

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

Ms Joanna Daly was found dead in her cell at HMP New Hall on 2 June 2019. She was 35 years old. The cause of her death is unknown, although the pathologist noted that it could be related to her previous drug use. I offer my condolences to Ms Daly's family and friends.

Ms Daly had been released from New Hall on licence on 20 May 2019 to Ripon House Approved Premises (AP). However, she failed to return to the AP on 22 May. In the early hours of 31 May, she was found by police in an intoxicated state. She was taken to hospital before being taken into police custody later that day. She was sent back to New Hall on 1 June.

Staff reported that Ms Daly looked unwell when she arrived and showed signs of withdrawal from drugs. She was checked hourly overnight but each time appeared to be asleep. She was discovered when her cell was unlocked at around 8.30am the next morning, by which time rigor mortis had set in, indicating that she had been dead for some hours.

The investigation found that the overnight checks were inadequate in terms of checking on Ms Daly's wellbeing. It is probable that she was dead when some of those checks were carried out. The prison needs to ensure that staff are clear on the purpose of the checks and that they assure themselves that prisoners are alive and well when carrying out overnight checks on newly arrived prisoners.

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

Sue McAllister CB
Prisons and Probation Ombudsman

February 2020

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Summary

Events

1. Ms Joanna Daly was released on licence from HMP New Hall on 20 May 2019. She was required to live at Ripon House Approved Premises (AP) as part of her licence conditions. She stayed at the AP for two days before failing to return on 22 May. She had a history of drug and alcohol abuse and there was evidence that she had taken drugs and alcohol while living at the AP.
2. In the early hours of 31 May, police found Ms Daly intoxicated in the street. She was taken to hospital where she spent several hours before being taken into police custody.
3. On 1 June, Ms Daly was sent back to New Hall. Reception staff at New Hall noticed that Ms Daly looked unwell. She showed signs of withdrawal from drugs and was prescribed methadone. She took her first dose later that day.
4. Healthcare support workers checked on Ms Daly hourly during the night, between midnight and 5.15am. Each time, they noted that Ms Daly appeared to be asleep. An officer carried out a roll check at 5.30am, and said that Ms Daly appeared to be asleep.
5. At around 8.30am on 2 June, an officer unlocked Ms Daly's cell and called out to her, but got no response. He then noticed her foot, which was protruding from her duvet, was blue. He called to a supervising officer (SO) who was nearby and they both went into the cell. Ms Daly was cold and they could not find a pulse. The SO radioed for medical assistance. Two members of healthcare staff arrived at the cell and realising that Ms Daly was unresponsive, asked the SO to radio an emergency code blue. One member of healthcare staff went to collect the resuscitation equipment and by the time she returned, staff had started cardiopulmonary resuscitation (CPR). However, when a nurse arrived, she asked for CPR to stop as Ms Daly was clearly dead.
6. The post-mortem examination and toxicology tests were unable to determine Ms Daly's cause of death.

Findings

7. We were told that all prisoners are checked hourly overnight in the First Night Centre at New Hall and that the purpose of these checks is to ensure that each prisoner is alive and well. However, the staff checking on Ms Daly just looked into the cell and noted that she appeared to be asleep; they did not satisfy themselves that she was alive. Ms Daly had been dead for some time when she was discovered at 8.30am and it is likely that she was dead when some of the checks were carried out.
8. We are concerned that the staff who discovered Ms Daly unresponsive did not call a medical emergency code straightaway. It made no difference in this case as Ms Daly was dead when found, but it is important that the correct medical emergency procedures are followed when a prisoner is found unresponsive so there is minimal delay in providing emergency care.

Recommendations

- The Head of Healthcare should ensure that staff carrying out hourly overnight checks in the First Night Centre understand the purpose of the checks and satisfy themselves that each prisoner is alive and well.
- The Governor should ensure that all staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies, in particular the need to use the correct medical emergency code.

The Investigation Process

9. The investigator issued notices to staff and prisoners at HMP New Hall informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
10. The investigator visited New Hall on 11 June 2019. She obtained copies of relevant extracts from Ms Daly's prison and medical records.
11. NHS England commissioned an independent clinical reviewer to review Ms Daly's clinical care at the prison. They jointly interviewed staff.
12. We informed HM Coroner for West Yorkshire of the investigation. The coroner gave us the cause of death. We have sent the coroner a copy of this report.
13. One of the Ombudsman's family liaison officers contacted Ms Daly's next of kin, to explain the investigation and to ask if they had any matters they wanted the investigation to consider. The family asked the following:
 - What time did prison staff first notice there was an issue with Ms Daly?
 - Did staff call a code blue?
 - Who pronounced Ms Daly's death?
 - Did staff perform CPR?
 - Information about Ms Daly's 30-minute checks overnight.

We have addressed these questions in this report.

14. We provided Ms Daly's next of kin with a copy of the initial report. They did not comment on this.

Background Information

HMP New Hall

15. HMP New Hall is a local prison, holding up to 425 women and young offenders, on remand or sentenced. There is 24-hour healthcare cover. Care UK have been the healthcare provider for all physical and mental health services since 1 September 2016, although South Staffordshire and Shropshire Foundation Trust are sub-contracted to provide psychiatric and psychological services.

HM Inspectorate of Prisons

16. The most recent inspection of HMP New Hall was in February and March 2019. Inspectors reported that overall, reception procedures were efficient and well delivered. Searches were proportionate and prisoners had reasonable access to toiletries and clean bedding. Inspectors found the First Night Centre to be decent and cells were clean and well equipped.
17. Inspectors found that most first night procedures were good, and prisoners with substance misuse problems received additional first night checks by a nurse.
18. Inspectors said the prison's drug and alcohol strategy was supported by a coherent action plan that was regularly reviewed. Support for prisoners arriving at the prison with drug or alcohol problems was effective and prisoners could continue with their existing prescribing regimes or equivalent treatment. Occasionally medical assessments were delayed in reception, but nurses ensured that prisoners were safely detoxified and effectively stabilised.

Independent Monitoring Board

19. 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 28 February 2018, the IMB reported that all prisoners were treated appropriately on their arrival at New Hall, and were offered hot food and a drink, and that a nurse assessed all prisoners either in reception or the First Night Centre (FNC).

Previous deaths at HMP New Hall

20. Ms Daly was the second prisoner to die at New Hall since October 2017. The previous death was self-inflicted. There are no similarities between the two deaths.

Key Events

21. On 7 August 2018, Ms Joanna Daly was sentenced to four months and 50 weeks in prison for sexual assault and theft. She was sent to HMP New Hall. During her time at New Hall, Ms Daly was on a methadone detoxification programme and worked with a substance misuse recovery worker. Before Ms Daly was released on licence, the substance misuse recovery worker noticed that her appearance had improved, she seemed more confident, and was looking forward to her future.

Ripon House Approved Premises

22. Ms Daly was released from New Hall on licence on 20 May 2019. She was required to live at Ripon House Approved Premises (AP) as part of her licence conditions. She was given a methadone prescription for 40mls daily, to be administered by a local pharmacy.
23. Ms Daly arrived at Ripon House after her 9.00pm curfew on 20 May, and admitted she had drunk alcohol. The next morning staff heard Ms Daly talking about buying drugs at Ripon House's back gate, and CCTV checks showed Ms Daly taking something from a member of the public. A subsequent search of her room showed evidence that she was using drugs. A manager at Ripon House, said that Ms Daly had stayed there previously and that her drug use had been an issue. On 22 May, Ms Daly left Ripon House, and did not return. As a result, her place at the AP was withdrawn and her licence was revoked.
24. In the early hours of 31 May, police found Ms Daly intoxicated in the street. She was taken to hospital. She was kept there for around seven hours before being taken into police custody in Grimsby.
25. Police noted that Ms Daly appeared lethargic and disorientated and she was placed on 30-minute 'rousal checks' (to check she could be woken) in a cell with a camera.

HMP New Hall

26. Ms Daly was returned to New Hall on 1 June. Her accompanying Person Escort Record (PER) recorded that she had a long history of drug use and had been taken to hospital after being found unconscious.
27. An officer saw Ms Daly when she arrived in reception. He remembered her when she had left the prison 11 days earlier, and recalled she had looked fit and well. This time the officer noticed that Ms Daly looked the "worse for wear". The officer escorted Ms Daly into reception and commented, "You've been bang at it", to which Ms Daly replied, "Fuck off". The officer noted that Ms Daly looked severely hungover, very pale and tired and she was wearing stained clothes. Ms Daly said she felt "rough" and was "rattling" and just wanted to go to a wing and go to bed.
28. An officer gave Ms Daly a Level A rub-down search (a mandatory searching requirement) and used the BOSS chair (Body Orifice Scanning System) and metal detector wand. Nothing was detected. (A full body search (sometimes

- called a strip search) would only be conducted if there was suspicion about that prisoner, and there was nothing to suggest Ms Daly needed an additional search.) The officer recalled that Ms Daly seemed “in a terrible state” and repeatedly said she felt unwell. She seemed desperate to see healthcare staff.
29. Ms Daly declined an offer to make a telephone call from reception, have a shower or food, but asked for a drink. She was given a cup of tea. Ms Daly was also offered a change of clothing, but she said she preferred to stay in her own, soiled, clothes.
 30. Ms Daly told the officers she had been smoking and injecting up to £100 worth of heroin daily, and had been taking £200 worth of cocaine and drinking strong lager daily. Ms Daly said she had no thoughts of suicide or self-harm and expressed no other concerns about her physical wellbeing.
 31. Ms Daly told a nurse in reception, that she was currently using alcohol and illicit drugs. The nurse noted that Ms Daly appeared disorientated and confused and that she was suffering withdrawal symptoms. The nurse noted that Ms Daly scored nine on the opiate withdrawal scale, indicating mild withdrawal. A urine test showed Ms Daly had taken cocaine, benzodiazepine and methadone, which she admitted having last taken the day before. The nurse referred Ms Daly to the prison’s substance misuse service (SMS).
 32. A GP assessed Ms Daly later that afternoon. Ms Daly told him that she began taking drugs immediately she was released, as they were available in the community. She said she used up to £100 worth of heroin a day, cocaine, benzodiazepines, diazepam, pregabalin and three or four cans of strong lager a day. The GP noted that Ms Daly displayed moderate to severe withdrawal symptoms. He prescribed a methadone withdrawal programme, starting at 1mg a day for 28 days, and noted that staff should monitor her withdrawal and that she should engage with SMS.
 33. Ms Daly was given a prison issue electronic vape machine and was then taken to the First Night Centre (FNC). She remained in the clothes she had worn when she arrived at New Hall, and was given her first dose of methadone.
 34. An officer saw Ms Daly when she arrived in the FNC, and spoke to her at about 7.20pm. They discussed what had happened on her release and spoke about her family.
 35. The officer carried out a roll check at 9.30pm, and remembered seeing Ms Daly. At 10.00pm, Ms Daly asked an officer for the time. The officer heard Ms Daly shout out at 10.40pm, in response to an incident in the FNC.
 36. Two healthcare support workers were responsible for carrying out hourly overnight checks on all prisoners in the FNC. They checked Ms Daly six times between them, between 12.10am and 5.14am. Each entry noted that she appeared to be asleep.
 37. An officer completed the morning roll check on the FNC at 5.30am. She told the investigator that Ms Daly appeared to be asleep.

38. An officer started work on the FNC at approximately 8.30am. Due to an incident the night before, a Supervising Officer (SO) told him to take one of the prisoners to collect her medication and then lock her back in her cell, before unlocking other prisoners in the FNC.
39. When the officer arrived at Ms Daly's cell, he unlocked the door and called her name, but got no response. Ms Daly was covered by her duvet, but the officer noticed her foot protruding from the side of the duvet, and it looked blue. The officer shouted to the SO who was in the office nearby. She ran to Ms Daly's cell and they both went in. The officer shook Ms Daly, who felt cold, and was unable to get a response. The SO felt for her pulse, but could not find one. The SO radioed for medical assistance at 8.48am.
40. Another officer, a healthcare support worker and a pharmacy technician, responded to the call for medical assistance. When the healthcare support worker and the pharmacy technician arrived, they realised that Ms Daly was unresponsive and asked prison staff to call a medical emergency code blue over the radio. The healthcare support worker then went to collect the resuscitation equipment as she had only taken basic equipment with her. When she returned, she saw that the officer started cardiopulmonary resuscitation (CPR). She thought that Ms Daly looked dead. However, when staff asked her if they should move Ms Daly to the floor to continue CPR, she agreed.
41. A nurse arrived at Ms Daly's cell at 8.53am, and saw her on the floor with the officer continuing with CPR. The healthcare support worker had prepared the defibrillator, ready to attach to Ms Daly. The nurse checked Ms Daly, but noted she felt stiff and cold. She assessed she had rigor mortis (indicating she had been dead for some hours). She told the officer to stop CPR and pronounced Ms Daly's death at 8.55am.

Contact with Ms Daly's family

42. The Deputy Governor, and an officer visited Ms Daly's next of kin to break the news of her death. The prison contributed to Ms Daly's funeral, in line with national guidance.

Support for prisoners and staff

43. After Ms Daly's death, the Deputy 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.
44. The prison posted notices informing other prisoners of Ms Daly's death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Ms Daly's death.

Post-mortem report

45. The post-mortem examination was unable to determine the cause of Ms Daly's death.
46. Toxicology tests were carried out and the toxicologist noted, "There has been exposure to illicit heroin and cocaine, but both these and their metabolites were low at the time of death," and, "There are no more than trace levels of alprazolam (benzodiazepine sedative), quetiapine (antipsychotic drug) and trazadone (antidepressant drug)." The pathologist considered that these findings indicated previous drug use, rather than acute drug use in prison. A test for PS showed that no PS were present.
47. The pathologist noted some subtle cocaine-induced changes to the heart and said that a cocaine-related cardiac death remained a possibility.
48. The pathologist noted no positive pathological findings that could prove Ms Daly was suffering from severe withdrawal around the time of her death. He considered a review by a medical practitioner experienced in the management of patients with drug dependency would be required to assess whether this might be a credible explanation for her death.
49. The pathologist concluded that the cause of Ms Daly's death was unascertained.

Findings

Overnight checks on the First Night Centre (FNC)

50. The Head of Healthcare told the investigator that all prisoners in the FNC were checked hourly overnight by healthcare staff. She said that staff were required to carry out a 'clinical observation', rather than just checking the prisoner was in the cell, and she would expect them either to get a response from the prisoner or note movement.
51. A healthcare support worker told the investigator that her role was to check prisoners hourly between midnight and 6.00am to make sure there was nothing untoward in their room and that the prisoner was in the cell. She said she did not try to get a response from the prisoners and sometimes she was unable to see them if they were under their duvet.
52. The Head of Healthcare accepted that some staff had different approaches to the FNC checks, with some just looking through the door and noting that the prisoner appeared to be asleep without checking for movement. She said that the prison was looking at introducing a clear policy on FNC checks. They were considering warning prisoners when they arrived that staff would need to satisfy themselves that the prisoner was safe and well during the night, which might require them to get a response.
53. We are concerned that the checks made on Ms Daly were inadequate in terms of checking on her welfare. They were not in line with the Head of Healthcare's expectations as no response was obtained or movement noted. This was a particular failing in Ms Daly's case as she was known to be suffering withdrawal symptoms. It is likely that Ms Daly was dead when some of the checks were carried out, given she had been dead for some time when she was discovered. We make the following recommendation:

The Head of Healthcare should ensure that staff carrying out hourly overnight checks in the First Night Centre understand the purpose of the checks and satisfy themselves that each prisoner is alive and well.

Emergency response

54. PSI 03/2013 requires prisons to have a medical emergency response code protocol, which should enable staff to clearly and concisely convey the nature of the medical emergency simultaneously to all relevant staff. New Hall's local policy says that a code red should be called where there is serious loss of blood, scalds or a suspected fracture and a code blue for chest pains, difficulty breathing, unconsciousness, choking, fitting, concussion, severe allergic reaction or suspected stroke. Calling a code tells healthcare staff to attend the scene immediately with the necessary equipment and staff in the communications room to call an ambulance immediately.
55. Neither an officer nor a SO called a medical emergency code when they discovered Ms Daly unresponsive in her cell. The SO called for medical assistance and healthcare staff responded quickly. However, because they did not know the nature of the incident, they did not take the resuscitation equipment

with them and had to collect it after they had arrived at the cell and realised Ms Daly was unresponsive. If a code blue had been called, healthcare staff would have known to take the resuscitation equipment with them and an ambulance would have been called automatically. The delay did not make a difference in this case, as Ms Daly was dead when found, but it is important for staff to follow the correct medical emergency procedures as any delay in a future emergency could be critical. We make the following recommendation:

The Governor should ensure that all staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies, in particular the need to use the correct medical emergency code.

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