Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Ms Nikita Hansen on 26 May 2020, following her release from HMP Eastwood Park

A report by the Prisons and Probation Ombudsman

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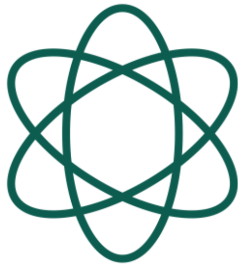
Our vision

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 Nikita Hansen died in hospital on 26 May 2020 from bronchopneumonia (a chest infection) caused by a hypoxic brain injury which in turn was caused by her attempted hanging on 2 January 2020 while a prisoner at HMP Eastwood Park. She was 33 years old. I offer my condolences to Ms Hansen's family and friends.

Ms Hansen had a history of mental health problems, attempted suicide, self-harm and substance misuse. Ms Hansen found being in custody challenging. She had been appropriately monitored under suicide and self-harm prevention measures (known as ACCT) on two occasions but was not being monitored at the time of her death.

The clinical reviewer was satisfied that the clinical care that Ms Hansen received at Eastwood Park was equivalent to that which she could have expected to receive in the community. He considered that throughout Ms Hansen's time in custody, she received a demonstrably high standard of support from members of the substance misuse and mental health teams.

While Ms Hansen had a number of significant risk factors which made her vulnerable to self-harm, we do not consider that staff could reasonably have predicted that she was at imminent risk of suicide in the days or hours before she tried to hang herself.

We have made no recommendations.

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 2021**

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Summary

Events

1. Ms Nikita Hansen had served time at a number of prisons. She had a history of mental health issues, attempted suicide, self-harm and substance misuse problems.

2. Ms Hansen was recalled into custody on 14 January 2019 and sent to HMP Styal, where she continued to be prescribed methadone (an opiate substitute).

3. Ms Hansen was transferred to HMP Eastwood Park on 11 June. She had periods of stability and instability and at times, she demonstrated a poor attitude and poor behaviour. The mental health and substance misuse teams supported her throughout her time in custody. She was monitored under ACCT procedures on two occasions between 23 July and 12 August and 6 September to 4 December. This represented a significant amount of her time at Eastwood Park. Records indicate that she harmed herself on four occasions, including tying a ligature around her neck on one occasion. Ms Hansen also used illicit substances.

4. At 2.44pm on 2 January 2020, a prisoner looked into Ms Hansen's cell and saw her hanging. The prisoner alerted prison officers who responded immediately and called the emergency services. Prison and healthcare staff tried to resuscitate Ms Hansen and established a pulse. When the paramedics arrived, they continued to give Ms Hansen emergency treatment.

5. She was taken to hospital, where they found that Ms Hansen had incurred a significant and irreversible brain injury which required extensive rehabilitative care.

6. On 15 April, due to her life-limiting health condition, HMPPS granted Ms Hansen early compassionate release from prison. She died on 26 May.

7. The Coroner's report noted that Ms Hansen died from bronchopneumonia, as a result of hypoxic brain injury caused by her attempted hanging.

Findings

Assessment of risk

8. Ms Hansen had several significant risk factors for suicide and self-harm when she arrived at Eastwood Park, which she had had for many years. We are satisfied that she was appropriately monitored under ACCT procedures whenever staff identified that she may be at risk and when she harmed herself.

9. We are also satisfied that staff were responsive towards her and checked on her wellbeing regularly in the days and hours before she died and we do not think that staff could reasonably have predicted that she was at imminent risk of suicide.

Clinical review

10. The clinical reviewer found that the clinical care that Ms Hansen received at Eastwood Park was of a good standard and equivalent to that which she could have expected to receive in the community.

The Investigation Process

11. The investigator issued notices to staff and prisoners at HMP Eastwood Park informing them of the investigation and asking anyone with relevant information to contact him. Nobody responded.

12. The investigator obtained copies of relevant extracts from Ms Hansen's prison and medical records.

13. NHS England commissioned an independent clinical reviewer to review Ms Hansen's clinical care at the prison.

14. The investigator interviewed nine members of staff and two prisoners (jointly) at Eastwood Park. The interviews were completed by video conference because of the restrictions imposed due to the COVID-19 pandemic.

15. We informed HM Coroner for Avon of the investigation. She gave us a copy of Ms Hansen's death certificate. We have sent the Coroner a copy of this report.

16. We contacted Ms Hansen's mother to explain the investigation. She said that she was extremely upset about the lack of support she received from the prison in terms of visiting her daughter when she was in hospital. We have addressed this issue in this report.

17. Ms Hansen's mother received a copy of the draft report. She did not make any additional comments.

18. HMPPS also received a copy of the report and identified some factual inaccuracies which have now been reflected within the report.

Background Information

HMP Eastwood Park

19. HMP Eastwood Park is a closed prison in Gloucestershire which holds up to 442 women. It has 10 residential wings, two of which specialise in substance misuse issues. NHS England commissions Bristol Community Health Community Interest Company (BCH) to provide health care services. BCH provides primary care services and sub-contracts some services to other providers, working as a partnership called Inspire Better Health. Bristol Community Health provides clinical substance misuse services. Avon and Wiltshire Partnership NHS Trust provides mental health services. Healthcare is provided 24 hours a day.

HM Inspectorate of Prisons

20. The most recent inspection of HMP Eastwood Park was in May 2019. Inspectors reported that care and support for prisoners was good and reception and induction procedures were comprehensive. They noted that new arrivals had an initial health screen with a nurse, focusing on risks and immediate needs, including those relating to substance misuse withdrawal. They found that secondary health screens were booked promptly to identify and address prisoners' health needs immediately, and that liaison with community services was good and helped to ensure continuity of care.

21. Inspectors found that demand for drug and alcohol services was high and prisoners with substance misuse issues were managed on a dedicated unit. Eastwood Park had introduced a pregabalin reduction programme, which offered support to help prisoners to reduce their dependency gradually, ensuring that they were prescribed clinically appropriate medication. Inspectors noted that health services were well integrated. They noted that the substance misuse strategy and management of medicines were robust and support had improved since the last inspection in 2016.

Independent Monitoring Board

22. 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 last published annual report for the year to 31 October 2019, the IMB noted that Eastwood Park was a well-run prison, where managers and staff treated prisoners with professionalism and care. The reception process was praised consistently by incoming prisoners who saw their overall initial experience at Eastwood Park in a very positive light.

23. The IMB noted that 48% of prisoners at Eastwood Park arrived with drug problems. It found that the prison tried very hard to provide a level of care that adequately and appropriately responded to those needs.

Previous deaths at HMP Eastwood Park

24. Ms Hansen was the first prisoner to take her life at Eastwood Park since August 2016. In the two years before her death, there were two drug-related deaths and one death from natural causes.

Key Events

Background

25. Ms Nikita Hansen had served a number of custodial sentences in several prisons since 2011 and had been recalled to custody a number of times. She had a significant history of substance misuse and self-harm, and had been monitored several times under suicide and self-harm procedures, known as ACCT. She also had emotionally unstable personality disorder.

26. On 28 December, Ms Hansen was released from prison on licence but was recalled to HMP Styal on 14 January 2019 for breaching her licence conditions. Ms Hansen's recall information pack noted that she showed vulnerability in custody, had a history of self-harm and substance misuse and was prescribed methadone (an opiate substitute).

27. On 21 March, Ms Hansen was transferred to HMP Low Newton. Staff monitored her under ACCT procedures from 18 April after she deliberately cut herself with a razor blade and tied a ligature around her neck. Ms Hansen said she had harmed herself out of frustration after an argument with another prisoner about her partner. Staff stopped ACCT monitoring on 3 June.

HMP Eastwood Park

28. On 11 June 2019, Ms Hansen was transferred to HMP Eastwood Park. A nurse completed her initial health screen and noted that she had a history of anxiety and psychological trauma (which included physical and sexual abuse). Ms Hansen said she had harmed herself "a few months" earlier but had no current thoughts of suicide or self-harm. She tested negative for drugs and said that she had not used any illicit substances in the last month. Ms Hansen said she was okay but was fed up with being transferred.

29. The prison doctor reviewed Ms Hansen's medical records and agreed to continue her methadone treatment.

30. On 12 June, a substance misuse worker assessed Ms Hansen and noted her history of misusing heroin, crack and subutex (an opioid). Ms Hansen said that she had been diagnosed with bipolar disorder, trauma and personality disorder and had not used any illicit drugs since her return to prison. She said that in 2011, she had had cervical cancer and was waiting for the results of a smear test she had had at Low Newton.

31. The substance misuse worker talked to Ms Hansen about how using drugs would have a negative impact on her. She noted that although Ms Hansen's methadone dosage was due to be gradually tapered until it was completely withdrawn, this was to be put on hold to allow her to settle into her new surroundings. She referred Ms Hansen to the mental health team and sent a task to the healthcare team about Ms Hansen's cervical screen concerns.

32. On 15 July, Ms Hansen told a member of the healthcare team that she was struggling with her mental health. This information was passed to the mental health team to book an appointment.

33. On 18 July, a nurse saw Ms Hansen to review her methadone detoxification progress. Although Ms Hansen said she wanted to "speed up" her detoxification, she felt that she had a lot going on mentally, including an impending hospital gynaecology appointment. The nurse agreed to maintain Ms Hansen's methadone dosage of methadone and review the situation.

34. That day, a nurse saw Ms Hansen to discuss her recent smear test result which indicated borderline cervical cell changes and noted the presence of the human papilloma virus (which increases the risk of cervical cancer). Ms Hansen was concerned about the result as she had had cervical cancer before. The nurse reassured Ms Hansen that the hospital would decide what tests and treatment she needed at her forthcoming appointment.

35. On 23 July, staff started ACCT procedures after Ms Hansen threatened to harm herself and said she would not leave the prison alive. The next day, a supervising officer chaired a multidisciplinary first ACCT review, and noted her history of self-harm, sexual abuse and bipolar disorder. Ms Hansen said she had difficulty sleeping. She wanted to be transferred to HMP Downview, where she believed she would receive better support as she had received eye movement desensitisation and reprocessing (EMDR, a form of psychotherapy support) there for post-traumatic stress disorder (PTSD) in 2014. Ms Hansen's ACCT caremap noted that the mental health team was due to assess her on 2 August and that she would continue to be monitored under ACCT procedures. It also noted that they would find out whether it was possible to transfer Ms Hansen. Staff also gave Ms Hansen distraction packs to help her make better use of her time when locked in her cell.

36. On 25 July, Ms Hansen had an altercation with prison officers while they were managing a serious incident on the wing. Staff issued Ms Hansen with a disciplinary warning which resulted in her incentive and earned privileges (IEP) level being reduced to basic for seven days. (This meant a loss of privileges such as a loss of her television and reduced time to mix with other prisoners.)

37. On 30 July, Ms Hansen attended a hospital appointment for a biopsy procedure. This meant that she missed a mental health appointment.

38. However, a mental health nurse saw Ms Hansen the next day. Her mood was low because she wanted to be referred for the EMDR programme. She said she had complex PTSD and bipolar disorder and had been due to start trialling medication that would have helped her. She said she was hearing voices more and lacked motivation. She denied having any thoughts of self-harm.

39. A mental health nurse assessed Ms Hansen the next day. She said she was not sleeping well and was isolating herself in her cell. She wanted a job and reiterated that she wanted to complete the EMDR programme. The nurse agreed to ask the psychology team if the EMDR programme was available at Eastwood Park. She referred Ms Hansen to the nurse prescriber to consider her medication options and asked wing staff if there were any job vacancies. Later that day, wing staff assigned Ms Hansen a job in the horticultural workshop.

40. On 4 August, Ms Hansen was verbally aggressive and used threatening behaviour towards staff. She was charged with indiscipline, the charge was proven, and she was given cellular confinement as a punishment. An ad-hoc ACCT review was

completed. A member of the healthcare team also tried to assess her but she refused to speak to her, other than to say that she was okay.

41. On 5 August, a supervising officer further conducted an ACCT review. Ms Hansen refused to attend so the review panel agreed to keep monitoring her. It was noted that Ms Hansen had not harmed herself since ACCT monitoring started. The ACCT caremap identified that Ms Hansen's appointment with the mental health team was rescheduled to 14 August.

42. On the afternoon of 7 August, Ms Hansen was back on the wing and attended the horticultural workshop. Staff noted that she was reluctant to participate in the workshop activities, displayed a poor attitude and refused to engage in conversation. The next day, staff noted she engaged and had a much better and more positive attitude when she attended the workshop.

43. Following an ACCT review on 12 August, the panel agreed to stop ACCT monitoring. ACCT observations had already been lowered. The panel noted that Ms Hansen continued to work with the mental health team, was being supported in therapy groups and had been offered one-to-one support sessions. Ms Hansen said she enjoyed attending the horticulture workshop. She also attended the pagan group, with support from the chaplaincy. She talked about having thoughts of self-harm but said she had had them since the age of five and had no intention of acting on them.

44. On 14 August, a mental health nurse saw Ms Hansen who described having flashbacks about her past trauma and said she was not sleeping well. She felt institutionalised as she had spent long periods of time in prison. However, she talked about having a future and wanting to build a life for herself when she was released from prison. The nurse noted that Ms Hansen's mood was low but she said she had no thoughts of suicide or self-harm. While Ms Hansen had said that she had previously been prescribed various mental health medications, the nurse checked and was unable to confirm a diagnosis of bipolar disorder in her medical records. She noted that Ms Hansen displayed no serious mental illness symptoms but would likely benefit from long-term psychological treatment such as the Nexus personality disorder outreach programme. She prescribed Ms Hansen a low dosage of trazodone (an antidepressant) which she took throughout her time in prison.

45. On 24 August, a wing officer noted that Ms Hansen appeared desperate to be transferred to another prison, despite having some good friends on the wing. Staff had also noticed that Ms Hansen involved herself in other prisoners' situations and tended to become too emotional, being rude and threatening towards staff, exhibiting poor behaviour on occasions and receiving disciplinary sanctions.

Events between September and December 2019

46. On 5 September, staff gave Ms Hansen a disciplinary warning after it was reported that she was involved in an alleged serious assault on another prisoner. Her IEP level was reduced to basic and the matter was referred to the police for investigation.

47. The next day, staff started ACCT procedures after Ms Hansen cut herself with a razor blade after she was told that she was to move to a different wing that day, due

to the ongoing police investigation. Staff referred Ms Hansen to the mental health team.

48. A supervising officer held the first ACCT multidisciplinary review on 7 September, by which time Ms Hansen had been moved to Residential Unit 3 (from Residential Unit 1). All cells are single on this unit. Ms Hansen was now happy with her relocation and told staff that a fresh start was the best thing for her, and that she wanted a job to keep herself busy. She said she had no thoughts of self-harm but was concerned about the police investigation. The panel told her that she had to await the outcome of the police investigation and once her IEP level had reverted to standard, they would try and find a wing job for her. At the ACCT review the next day, Ms Hansen denied thoughts of self-harm.

49. On 12 September, following an ACCT review, staff increased Ms Hansen's observations after she made cuts to her arms. Ms Hansen remained worried about the police investigation. Staff agreed to return her television to help distract her. The next day, Ms Hansen's IEP level reverted to standard.

50. While the ACCT monitoring continued, Ms Hansen's mood fluctuated. Some days, she appeared happy and settled, and some days, her mood was low. Staff completed 17 ACCT reviews before ACCT monitoring was stopped on 4 December. During this time, Ms Hansen harmed herself on four occasions. On 15 October, she cut her arms and said she had tied a ligature around her neck (although no marks were found). On 20 October, she cut her arms and neck. On 13 November, she made minor scratches to her upper arm. Staff adjusted Ms Hansen's ACCT monitoring requirements.

51. A prisoner told us that it was not unusual for Ms Hansen to react impulsively by harming herself after she had had an argument with her partner. Sometimes, Ms Hansen harmed herself without staff knowing and the prisoner would help her clean her wounds. She said she told Ms Hansen that her actions could one day be fatal. She said that Ms Hansen appeared to accept this. Another prisoner told us that Ms Hansen was a private person and would "cut herself" to deal with her problems.

52. While Ms Hansen was being monitored under ACCT procedures, staff noted that her propensity to self-harm was "fairly predictable" and usually occurred in response to arguments with peers and/or bad news. On some occasions, Ms Hansen refused to say why she harmed herself. On other occasions, Ms Hansen said that she had harmed herself for several years as a way of coping and managing her emotions. Until 21 October, Ms Hansen's partner had also lived on the same wing, Residential Unit 3. Staff noted that Ms Hansen's relationship with her partner was counterproductive to her wellbeing as her self-harm tended to increase when they were together.

53. Ms Hansen had also stopped her methadone prescription on 18 September while she was being monitored by ACCT procedures as she wanted to start a rapid detoxification. However, she subsequently struggled with withdrawal symptoms, used illicit prescription drugs (buprenorphine and subutex) and tested positive for drugs. Her methadone programme, therefore, was restarted on 21 October.

54. By the time ACCT monitoring was stopped (on 4 December), the substance misuse and mental health team had played a consistent role in supporting Ms Hansen. She had attended a number of sessions with the psychological therapy group, had one-

to-one sessions with the mental health team and had a job on the wing. She also received support from the Nexus personality disorder programme and attended mindfulness sessions. On the whole, wing staff noted that Ms Hansen appeared to be “making an effort to better herself” and had made good progress.

Events from 5 December to 1 January 2020

55. On 5 December, Ms Hansen attended a substance misuse appointment. She said she felt stable on her current methadone dosage.

56. While staff mostly noted no concerns about Ms Hansen, they noted that her mood had been low on one occasion, and that she spent a lot of time talking about her daughter, her mother and her relationship with her partner. Ms Hansen continued to attend the Nexus programme workshops.

57. On 12 December, at her one-to-one session with a mental health nurse, Ms Hansen said she was doing her best to remain drug-free and had tested negative for drugs the previous week. She still felt anxious and said this was because she was not on the same unit as her partner. Prison managers agreed to consider locating her on the same wing.

58. On 16 December, Ms Hansen complained that her trazadone (an antidepressant) was not working and made her feel worse. A mental health nurse assessed her and agreed to review her medication. The nurse noted that Ms Hansen denied having current thoughts of suicide or self-harm. A mental health nurse tried to speak to Ms Hansen about her medication later that day but she had gone to the chapel.

59. On 19 December, a member of the substance misuse team reviewed Ms Hansen who was positive and talked about engaging in community support on release so that she could live without drugs. The Offender Management Unit had also told Ms Hansen that she was eligible for early release.

60. That day, Ms Hansen complained of chest pains. A nurse examined her and booked her in to attend the asthma clinic for a review.

61. On 23 December, the asthma nurse examined Ms Hansen, gave her advice and prescribed her an inhaler. That day, prison managers moved Ms Hansen to Residential Unit 1, the same unit as her partner.

62. On 25 December, staff found Ms Hansen and her partner apparently under the influence of an illicit substance.

63. The next day, staff told Ms Hansen that she was being moved back to Residential Unit 3 because of her poor behaviour. Ms Hansen initially refused and was given a disciplinary warning which resulted in cellular confinement. The disciplinary warning resulted in a suspended award of seven days loss of association, TV and dining. The award was suspended for six weeks.

64. On 27 December, Ms Hansen agreed to move back to Residential Unit 3. An officer spoke to Ms Hansen as she was unhappy and felt that the move was unfair. Before her move, Ms Hansen said that she would have harmed herself if she did not have a cellmate as she was frustrated about the situation. The officer spoke to her to

check on her wellbeing and explain in detail why she was being moved. Once the move had taken place, the officer talked to Ms Hansen who appeared content and said that there were lots of people with whom she got on. He said that she told him that she would not harm herself and that she had felt frustrated at the time but did not need to be monitored under ACCT procedures. The officer assessed that he did not need to start ACCT procedures as he was satisfied that she posed no increased risk of self-harm.

65. On 31 December, a nurse and a healthcare assistant, both from the mental health team, saw Ms Hansen during a therapies' programme workshop. The healthcare assistant noted that Ms Hansen appeared upset at times and slightly deflated. Ms Hansen said that she believed she had personality disorder, PTSD, was hearing voices and felt anxious. The nurse referred Ms Hansen to the low mood therapy group to help her develop coping skills.

2 January 2020

66. On the morning of 2 January, a nurse from the substance misuse team reviewed Ms Hansen who complained of sleep difficulties. She said she was happy and stable on her current dose of methadone but was not happy that she no longer lived on the same wing as her partner. The nurse prescribed her zopiclone (a sleeping aid).

67. Two prisoners who lived on Residential Unit 3 told us that Ms Hansen had been in a good mood that morning and they had all laughed and joked together. However, late that morning, while collecting her medication (in a communal area of the prison), Ms Hansen had an argument with her partner who lived on Residential Unit 1. The two prisoners said that Ms Hansen's mood was low after this. There is no evidence that staff knew about her argument.

68. Shortly before 11.00am, the healthcare assistant from the mental health team visited Ms Hansen in her cell. He gave her information about EMDR therapy and spoke about referring her to an anger management group. Ms Hansen said that she was looking forward to it as she had been feeling down. She said that she was working extremely hard to become a better person, even though it was a daily struggle not to hurt herself or someone else. The healthcare assistant reassured her that she was doing well and offered to give her a distraction pack to use in her cell. Ms Hansen was happy to accept this.

69. At around 12.30pm, an officer locked Ms Hansen in her cell after prisoners' lunch break and completed a roll check.

70. The healthcare assistant returned to deliver the distraction packs to Ms Hansen at around 12.45pm. He opened Ms Hansen's cell observation panel and called her name. Ms Hansen did not respond. The healthcare assistant went into the cell and saw Ms Hansen balanced on her toes, with her head down the toilet. He quickly left the cell and alerted an officer, who was nearby on the wing. They both returned to Ms Hansen's cell immediately.

71. The officer said that when she went into Ms Hansen's cell, she was standing up, folding some of her clothes, and she appeared upset. The officer tried to talk to Ms Hansen, but she asked to be left alone. The officer told Ms Hansen that she would return and check on her shortly. The officer told us that between 12.45pm and

1.45pm, she returned to Ms Hansen's cell on two occasions to check on her wellbeing. Each time, Ms Hansen was sitting on her bed, listening to music and no longer appeared upset. She still did not want to talk to the officer, and simply shook her head.

72. From around 2.30pm, three officers were completing their usual duties on Residential Unit 3. They had unlocked a number of prisoners to attend education classes and to collect their medication.

73. Just before 2.44am, two prisoners were on the wing landing. One of them looked through Ms Hansen's cell observation panel and saw Ms Hansen hanging from her cell door. She screamed to alert staff.

74. Three officers responded and ran to Ms Hansen's cell, at the top of the landing stairs. The prisoner who screamed was in shock and said that Ms Hansen was hanging. An officer ran to Ms Hansen's cell, looked through the observation panel and saw Ms Hansen's body behind the door. He immediately entered the cell followed by another officer and saw that Ms Hansen was hanging from the hinge of the door, with her feet suspended off the floor. Meanwhile, another officer radioed a medical emergency code blue. The prison control room log recorded that this occurred at 2.44pm and an ambulance was called immediately.

75. An officer cut the ligature and another officer helped him to lower Ms Hansen onto the floor. The officer said that Ms Hansen showed no signs of life and there was blood all over the floor. During his assessment, he saw what looked like fresh self-harm cuts on her arms and wrists. He cleared Ms Hansen's airway and the other officer started cardiopulmonary resuscitation (CPR).

76. Within a minute, a healthcare assistant arrived at Ms Hansen's cell and started to manage the incident. The staff pulled Ms Hansen out onto the wing landing to create more space. The healthcare assistant and a nurse took over CPR, using medical equipment they had brought to the scene. More healthcare staff responded to the emergency and helped with resuscitation efforts. Nursing staff attached a defibrillator, which indicated there was no shockable rhythm, and so they continued CPR.

77. Resuscitation continued until around 2.55pm when a pulse was detected. Ms Hansen was then able to breathe without assistance. When the ambulance and paramedic crew arrived at 3.00pm, they took over care, and transferred Ms Hansen to hospital, where she was admitted to the Intensive Therapy Unit (ITU). Healthcare staff received daily updates from the hospital.

Contact with Ms Hansen's next of kin

78. The prison appointed a Supervising Officer (SO) and an officer as the prison family liaison officers. Ms Hansen had nominated her partner in the community as her next of kin. At 4.05pm, the family liaison officer informed him about the incident and that Ms Hansen was in hospital. Ms Hansen's partner said that he did not intend to visit her in hospital.

79. The family liaison officer contacted Social Services and the police to find out contact details for Ms Hansen's family from whom she had been estranged for some time. Ms Hansen's brother was later identified and the family liaison officer broke the

news of Ms Hansen's hospitalisation to him on 3 January. Ms Hansen's brother told their mother and other family members.

80. The family liaison officers met Ms Hansen's family at the hospital on 5 January. She was still unconscious, not responding and she needed a ventilator to breathe. It was initially thought that Ms Hansen may have brain damage. Over the next few days, Ms Hansen showed little medical change and remained unable to breath unaided.

81. On around 10 January, the hospital consultant neurologist told Ms Hansen's family and the prison family liaison officers that Ms Hansen was not brain dead but had a brain injury, the extent of which was not known. The hospital consultant stated that any progress Ms Hansen made would be "very, very slow".

82. On 13 January, the hospital confirmed that Ms Hansen was no longer sedated. They planned to gradually reduce her reliance on the ventilator and test whether her brain signals were being transmitted to her limbs. This would allow her to be moved from ITU to a ward.

83. Ms Hansen gradually had prolonged periods without the ventilator. On 23 January, she was moved to a high observation bay on a neuro-surgery ward. It was intended that Ms Hansen would move to a rehabilitation unit elsewhere.

84. On 5 February, the hospital consultant confirmed that Ms Hansen had severe brain damage. The consultant was unsure of Ms Hansen's level of consciousness or if she was even aware of her surroundings. While it was expected that she would regain consciousness, the consultant considered that she would remain in a vegetative state despite her body breathing unaided. The consultant said that Ms Hansen could soon be moved to a rehabilitation centre. The consultant was unable to confirm how long Ms Hansen could live for, noting it "could be years".

85. On 14 February, the Deputy Governor submitted an application to the Public Protection Casework Section (PPCS) to consider whether Ms Hansen could be released from prison early on compassionate grounds. While Ms Hansen's death was not imminent, Eastwood Park was unable to support her medical needs.

86. The prison provided ongoing support to Ms Hansen's mother and family members, including facilitating visits. Ms Hansen's mother last saw her daughter on 9 March 2020 and was unable to visit her in hospital again due to the COVID-19 pandemic.

87. On 7 April, Ms Hansen was transferred to The Dean Hospital which specialises in 24-hour nursing and therapy services for people with complex, long-term neurological conditions and for those with brain and/or spinal injuries who require ongoing support and assistance to maximise functional ability.

88. On 15 April, PPCS approved Ms Hansen's application for early compassionate release. The prison's family liaison officers discussed this with Ms Hansen's mother and arranged to return Ms Hansen's personal belongings once COVID-19 restrictions were lifted.

89. On 25 May, Ms Hansen contracted pneumonia and died the next day on 26 May. The family liaison officer contacted Ms Hansen's family and offered condolences. Although Ms Hansen was not a serving prisoner, the prison offered to contribute towards her funeral expenses.

Support for prisoners and staff

90. A prison manager debriefed the prison and healthcare staff involved in the emergency response and offered his support and that of the staff care team, who were also present.

91. The prison posted notices informing prisoners of Ms Hansen's death, and offering support. Staff reviewed all prisoners assessed as at risk of suicide and self-harm, in case they had been adversely affected by Ms Hansen's death.

Cause of death

92. The Coroner's report noted that Ms Hansen died from bronchopneumonia as a result of hypoxic brain injury caused by her attempted hanging.

Findings

Assessment of risk

93. Mr Hansen had a number of risk factors, including a history of attempted suicide, self-harm, mental health issues, substance misuse and trauma. These were identified when she arrived at Eastwood Park and in line with Prison Service Instructions (PSI) 64/2011 on safer custody, staff appropriately monitored her under ACCT procedures. Various healthcare practitioners also supported Ms Hansen.

94. Although Ms Hansen had been subject to ACCT monitoring for long periods, she had not been managed under them for around four weeks at the time she was found hanging in her cell. While Ms Hansen sometimes admitted she struggled in prison, staff made positive comments about her attitude and mood during this four-week period. Ms Hansen engaged with support services and gave staff no indication that she was at imminent risk of suicide.

95. On the day that Ms Hansen was found hanging, prisoners believed that she had been upset about an argument with her partner that morning. Staff did not know about this. Between 11.00am and 2.44pm (when she was discovered), staff (including a member of the mental health team) had six interactions with her, checked on her welfare regularly and were responsive to changes in her behaviours. While staff acknowledged that Ms Hansen's mood appeared low, we are satisfied that she gave them no indication that she was at imminent risk of self-harm. When staff last interacted with her, Ms Hansen was sitting on her bed, listening to music and apparently no longer appeared upset.

96. While Ms Hansen had a number of significant risk factors such as personality disorder, anxiety and PTSD which made her vulnerable to self-harm, we do not consider that staff could reasonably have predicted that she was at imminent risk of suicide in the days or hours before she tried to hang herself. Ms Hansen's actions appear to have been impulsive.

Clinical care

97. The clinical reviewer concluded that the clinical care that Ms Hansen received at Eastwood Park was of a good standard and was equivalent to that which she could have expected to receive in the community.

98. The clinical reviewer said in particular that Ms Hansen received a mostly demonstrably high standard of support from both mental health and substance misuse teams throughout her periods in custody. He noted that Ms Hansen received appropriate medication to help facilitate her detoxification from substance misuse.

99. He concluded from Ms Hansen's medical record that her emotionally unstable personality disorder meant that she would on occasion harm herself impulsively in reaction to triggers – for example, a change of circumstances. He noted that while her actions were therefore not out of character, it would not have been possible to predict the events of 2 January.

Contact with Ms Hansen’s family

100. PSI 64/2011 on safer custody requires prison staff to communicate with the next of kin of prisoners who are seriously or terminally ill and following their death. Ms Hansen’s mother was unhappy that Eastwood Park had not contributed enough financially in supporting the family to visit Ms Hansen while she was in hospital. Specifically, she wanted Eastwood Park to fund a rail travel warrant every two weeks as the hospital was more than 200 miles from her home. Ms Hansen’s mother said she was elderly, had mobility problems (so could not travel too often) and had to use her state benefits when she visited Ms Hansen in hospital.

101. The prison family liaison officer confirmed that between 2 January and 9 March, Ms Hansen’s mother visited Ms Hansen on three occasions. Eastwood Park granted a free travel warrant (for two people) for the train journey each time at a cost of £480 return per trip.

102. On Ms Hansen’s mother’s first visit, the hospital provided five days of accommodation. On the second visit, she stayed in a hotel (at her own expense) for four nights. Ms Hansen’s mother (and stepfather) last visited Ms Hansen for a four night stay from 5 to 9 March. They paid for their own accommodation, although the prison paid for an additional night’s accommodation. Ms Hansen’s mother last visited her daughter on 9 March and was unable to visit again due to the COVID-19 pandemic. However, before the lockdown began, prison managers had agreed to continue to help Ms Hansen’s mother financially with travel warrants and accommodation while her daughter remained in hospital.

103. Although we appreciate that Ms Hansen’s mother may have wanted additional travel warrants, we do not consider that it would have been reasonable to expect that Eastwood Park could provide this form of support over a prolonged and unknown period. Eastwood Park had given Ms Hansen’s mother six travel warrants up to 9 March and it had been agreed before Ms Hansen’s death that additional travel warrants would be made available for the family. Sadly, further visits could not take place due to the COVID-19 lockdown.

104. Ms Hansen’s long-term hospitalisation was an unusual and sensitive situation. The prison family liaison log shows substantial evidence that the family liaison officers engaged, offered support and maintained good and continuous contact with Ms Hansen’s family while she was in hospital. This included the family liaison officers visiting Ms Hansen in hospital and updating her mother on her progress during the times she was unable to attend the hospital. In addition, the prison arranged for Ms Hansen’s mother and other family members to be driven to and from the train station, hotel and hospital when they visited.

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