

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Ms Emma Saxon, a prisoner at HMP New Hall, on 7 March 2022

A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

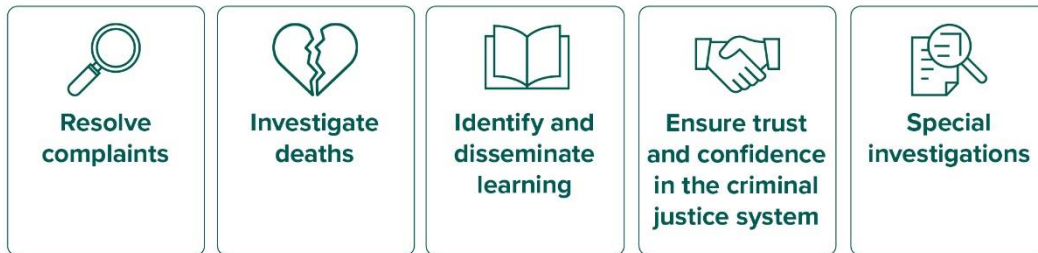
Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T | 020 7633 4100

OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO



WHAT WE VALUE



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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.

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Ms Emma Saxon died in hospital of a hypoxic brain injury on 7 March 2022, after she was found hanging in her cell in HMP New Hall on 3 March. She was 33 years old. I offer my condolences to her family and friends.

We found that staff at New Hall supported Ms Saxon well, were responsive to her individual needs and adapted processes accordingly. She had a history of self-harm and staff managed the risks proactively and consistently, with multidisciplinary input. In the months before her death, Ms Saxon experienced a period of unrest relating to a letter she sent to a prisoner on her unit with whom she was in a relationship. Staff provided appropriate advice on the relationship. However, we identified inconsistencies between national requirements about managing prisoners' relationships and New Hall's local guidance.

The clinical reviewer concluded that overall, the clinical care provided to Ms Saxon was equivalent to that which she could have expected to receive in the community.

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

Caroline Mills
Acting Deputy Prisons and Probation Ombudsman

February 2023

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Summary

Events

Background

1. Ms Emma Saxon was remanded in custody in October 2018, charged with arson. It was not her first time in prison. She had mental health issues and was managed under suicide and self-harm prevention procedures, known as ACCT, several times during her time at New Hall.

The Rivendell Unit

2. In August 2020, Ms Saxon moved to Rivendell House, a therapeutic unit for women with personality disorders. In December 2021, she made a cut to her arm and staff opened ACCT procedures to manage the risks. When ACCT monitoring later ended, she told staff she was working on expanding her coping strategies.
3. On 17 January, Ms Saxon disclosed that she was in a relationship with another prisoner on the unit. She was upset when staff told her that relationships were discouraged, and she asked to leave Rivendell House.
4. On 27 January, the prisoner with whom Ms Saxon was having a relationship received a letter signed by another prisoner on the unit, saying that she had feelings for him. However, the supposed sender denied writing it. Staff suspected that Ms Saxon might have been the author and, after initially denying it, she told staff she was. The following day, she retracted this and said that staff had pressurised her into admitting she was the author of the letter.
5. On 2 February, Ms Saxon and the prisoner with whom she was having a relationship were seen kissing. Staff told them that physical contact was not allowed. That afternoon, Ms Saxon told her prison offender manager that she had thoughts of hanging herself and staff opened ACCT procedures. Over time, she seemed to become more positive. ACCT procedures were closed.
6. On 2 March, Ms Saxon told the prisoner with whom she was having a relationship that she had written the letter on 27 January. That afternoon, Ms Saxon handed four apology letters to her keyworker, asking him to pass them on. The keyworker checked the content and had no concerns about Ms Saxon's wellbeing. The content was hopeful. He told her that he would discuss the letters with colleagues the following morning.
7. On the morning of 3 March, staff discussed the apology letters written by Ms Saxon. They agreed that they would not share them on her behalf but would encourage her to do so herself, with their support, and offered mediation on any follow-up conversations with her peers. An officer went to her cell to discuss this with her and found her hanging. Staff provided medical aid and Ms Saxon was transferred to hospital for further treatment. She died four days later.

Findings

Assessment of risk

8. Staff were aware of Ms Saxon's history of self-harm and were responsive when there was evidence that the risk was increasing. On 2 March, the day before her death, staff assessed whether risks had increased following receipt of Ms Saxon's apology letters. They considered her previous cycles of behaviour and the potential consequences of the letters, once received by her peers, and judged that ACCT procedures were not necessary at the time. This appears to have been a reasonable conclusion, despite the events that followed.

Relationships between prisoners

9. When Ms Saxon's relationship with another prisoner became clear to staff, they discussed this with her and assessed that there was no evidence of any risk to either individual. This was reasonable and in line with national instructions.
10. We found that New Hall's local Healthy Relationship Guidance was inconsistent with national policy. This did not impact on the management of Ms Saxon's relationship but should be addressed to ensure national requirements are met.

Ms Saxon's healthcare

11. The clinical reviewer was satisfied that Ms Saxon's healthcare was appropriate. However, when ACCT procedures were opened in early February, her clinical risk proforma was not updated and therefore records were out-of-date.

Recommendations

- The Governor should ensure that the Healthy Relationship Guidance accurately reflects Prison Rules.
- The clinical lead of Rivendell House should ensure that all risk assessments are reviewed when there are concerns about prisoners' raised levels of risk of suicide and self-harm.

The Investigation Process

12. 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 him. One prisoner responded, and the investigator interviewed her.
13. The investigator obtained copies of relevant extracts from Ms Saxon's prison and medical records.
14. The investigator interviewed five members of staff and two prisoners at New Hall in April and July 2022.
15. NHS England commissioned a clinical reviewer to review Ms Saxon's clinical care at the prison. The investigator and clinical reviewer jointly interviewed healthcare staff.
16. We informed HM Coroner for West Yorkshire, Eastern District of the investigation. He gave us the results of the post-mortem examination. We have sent him a copy of this report.
17. One of the Ombudsman's family liaison officers contacted Ms Saxon's stepfather, to explain the investigation and to ask if her family had any matters they wanted us to consider. He asked about the assessment of Ms Saxon's risk of self-harm.

Background Information

HMP New Hall

18. HMP New Hall is a local prison, holding up to 425 adult and young adult female offenders who are on remand or have been sentenced. Healthcare is available 24 hours a day. Care UK provides healthcare services for all physical and mental health needs, and South Staffordshire and Shropshire Foundation Trust are sub-contracted to provide psychiatric and psychological services.
19. Rivendell House is a therapeutic programme run in a self-contained unit of 30 en-suite rooms. It is aimed at women with a personality disorder and those with enhanced privileges status (prisoners who exhibit responsible behaviour and earn certain privileges). The unit provides a mixture of clinical and therapeutic work aimed at risk reduction. Greater Manchester Mental Health and Social Care NHS Trust provide services on the Rivendell Unit.

HM Inspectorate of Prisons

20. The most recent inspection of HMP New Hall was an unannounced inspection in February and March 2019. Inspectors reported that New Hall was a good prison, delivering effective outcomes. They found that Rivendell House was an effective offending behaviour initiative. Staff knew about the needs of prisoners in their care and showed exceptional understanding and patience. Antisocial behaviour was managed well and working relationships between staff and prisoners were positive. They also reported that the Challenge, Support, and Intervention Planning (CSIP) scheme seemed to be working well.

Independent Monitoring Board

21. 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 2021, the IMB reported that the prison was generally well run and a safe place to be. Relationships between staff and prisoners were generally good, although tested by the challenges of the COVID-19 lockdown.

Previous deaths at HMP New Hall

22. Ms Saxon was the fourth prisoner to die at New Hall since the beginning of 2020. The previous three deaths were due to COVID-19. There were no similarities between the findings across these investigations.

Assessment, Care in Custody and Teamwork

23. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner.

24. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular multi-disciplinary review meetings involving the prisoner. As part of the process, a caremap (plan of care, support, and intervention) is put in place. The ACCT plan should not be closed until all the actions of the caremap have been completed.
25. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Challenge, Support and Intervention Planning (CSIP)

26. CSIP is a Prison Service scheme designed to address factors contributing to violence in prisons by managing the most violent prisoners and supporting the most vulnerable prisoners. Prisoners who are perpetrators of violence or who are vulnerable to violence or bullying are managed and supported on a plan with individualised targets and regular reviews.

Key Events

Background

27. Ms Emma Saxon was remanded to HMP New Hall in October 2018, charged with arson. It was not her first time in New Hall. Ms Saxon had a diagnosed personality disorder and a learning disability. She had a history of anxiety, depression, and alcohol misuse, and had harmed herself on several occasions. In the past she had been supported under ACCT procedures.
28. On arrival at New Hall, staff noted Ms Saxon's history of self-harm and opened ACCT procedures to support her during the transition. She was referred to the mental health team.
29. Over the months that followed, Ms Saxon was monitored under ACCT procedures on several occasions after harming herself. On some of these occasions, she used a ligature to do so. Ms Saxon told staff that she struggled to ask for help and was concerned about her medication.
30. In March 2019, Ms Saxon was convicted of arson and being reckless as to whether life was endangered. In May, she was escorted to her sentencing hearing, where she was sentenced to four years imprisonment. Initially, she said that she felt positive about the outcome but in July, she admitted to thoughts of harming herself and ACCT monitoring was started. She said that she was being intimidated by two other prisoners, so a Challenge, Support and Intervention Plan (CSIP) was also opened to support her.
31. In April, staff started to discuss Rivendell House with Ms Saxon. They thought a move there might support the risk reduction objectives within her sentence plan. Ms Saxon wanted to apply, and the assessment process began in June. A formal application was submitted in January 2020, which was due to be considered in February but was delayed until July as the result of staffing issues caused by the COVID-19 pandemic. A multidisciplinary meeting agreed that the environment was more suitable than the general population for meeting Ms Saxon's risk reduction objectives.

Transfer to the Rivendell Unit

32. Ms Saxon moved to Rivendell House in August 2020.
33. In January 2021, Ms Saxon attended one of her regular clinical review meetings on the unit. She discussed some difficult issues with the clinician. Later that day, she made cuts to her arm. Staff started ACCT procedures, which were in place for three days, to monitor her wellbeing.
34. Later in January, Ms Saxon started experiencing pain in her gallbladder. In early February, she attended hospital for surgery to remove the gallbladder.
35. In March, Ms Saxon heard that she had been refused parole. Staff observed that she seemed to accept the decision and had no concerns about her response.

36. In April and May, Ms Saxon complained that she was unhappy about the location of her room because of the noise caused by other prisoners. Records show that she stopped complaining after a while and appeared to settle on her spur.

December 2021 – January 2022

37. In December, Ms Saxon made a cut to her arm. She said that she was frustrated by the amount of time she had spent in her room (this was due to operational issues across the prison, as well as ongoing health issues relating to heartburn and pain in her lower back). Staff started ACCT procedures immediately and held an opening meeting with Ms Saxon, as part of standard protocols. She said that she had realised that self-harm was not an effective way of relieving stress and was aware of all the support available to her. The ACCT was closed the following day. Later in December, at a multidisciplinary post-closure review (to ensure that ACCT support was still not required), Ms Saxon said that she was working on expanding her coping strategies. She said that she found self-harm less effective than other strategies.
38. On 10 January 2022, Ms Saxon attended a therapy session with a consultant clinical and forensic psychologist, an officer and a clinical psychologist. Staff asked Ms Saxon to consider the goals she had set when she applied for the Rivendell programme. She said that her main goal was to achieve her parole. The consultant psychologist reminded her that she had said that she wanted to achieve a better understanding of herself. Ms Saxon said that she felt she understood herself a little better but was focused on diagnoses. She said she had learned to walk away from conflict but still had difficulties getting along with others. She could struggle to solve problems and behave impulsively when feeling emotional. While she still had difficulties managing her emotions, she had learned that self-harm was not effective and tried to use alternative strategies. Ms Saxon also said that she was concerned about confusing the two strands of therapy she was engaging with on the unit. Staff explained how they differed, and she agreed to continue with the programme.
39. On 17 January, in a prisoners' community meeting, Ms Saxon disclosed that she was in a relationship with Prisoner A. Staff said that she should have discussed the relationship with them, as this was not allowed by Prison Rules, and Ms Saxon became upset. She later wrote a letter asking to move from Rivendell House. Staff submitted an intelligence report about the relationship in line with the local policy and organised a further discussion with Ms Saxon and Prisoner A to advise them of the rules. They both said that it was a platonic relationship, not a physical one, and therefore within the rules. Staff agreed that there did not appear to be any risks associated with the relationship at that stage, but that they would monitor the situation.
40. On 20 January, Ms Saxon attended her 12-month review meeting for Rivendell House. These were a standard procedure for residents on the unit. An offender supervisor, an offender manager, and two workers from the Together Women Project (TWP, a mentoring and advocacy service) also attended. Ms Saxon said that she felt that she had learnt to be more assertive and gave the example of having announced in the community meeting that she was in a relationship. She told the meeting that she was disappointed with some aspects of Rivendell House's

regime (specifically, access to work, education, and meaningful activity), which had not been as she expected it to be. She said that she had given up opportunities provided in the main population by transferring to Rivendell House, including two parole hearings, mentoring, and developing work skills. The offender manager explained that regime restrictions were due to COVID-19. She also said that it was unlikely that Ms Saxon would be granted parole without having undergone treatment. Staff reminded Ms Saxon of the support systems available in the unit and encouraged her to talk to professionals involved in her care when making important decisions. Ms Saxon appeared to accept the advice and said that she could see herself having a future on the unit.

41. On 27 January, Ms Saxon had a therapy session with the clinical psychologist. The consultant psychologist and an officer were also present. Ms Saxon said that she had changed her mind after the 12-month review meeting and wanted to stay in Rivendell House. The psychologist asked what had made her want to leave, and Ms Saxon became tearful, saying that she had been let down by professionals in the past. She said that she had harmed herself before Christmas because staff were not meeting her needs. She also explained that she was having difficulty with one of the programmes she was undertaking on the unit and when she realised that she could leave, it seemed a way out of the programme.
42. On 27 January, Prisoner A found a letter in his (the prisoner's preferred choice of pronoun) cell. It appeared to be from another prisoner, Prisoner B. The letter stated that Prisoner B had feelings for him. Prisoner A confronted Prisoner B, who became upset and denied writing the letter. Prisoner A handed the letter to staff.
43. On 31 January, a Supervising Officer (SO), who was the unit manager, and the consultant psychologist spoke to Ms Saxon about the letter. They pointed out that the handwriting was very similar to hers and she had a pen in her cell that matched the one used to write the letter. They asked her about her relationship with Prisoner A. Ms Saxon said that she was aware that prison policy did not allow intimate relationships between prisoners but said she and Prisoner A shared no physical intimacy. She said could not understand why staff were concerned because they provided good support for each other. The psychologist explained the importance of focusing on treatment when resident on the Rivendell House. Staff asked on several occasions if Ms Saxon had written the letter, which she denied before eventually admitting that she had done so. The SO and psychologist praised her for her honesty and for taking responsibility. When asked why she had written the letter, Ms Saxon gave several reasons, including trying to test the strength of the relationship, perhaps as a result of her tendency to sabotage her own relationships. She said she had seen how upset Prisoner B had been but did not want anyone to know she had written it. The SO said that she would open CSIP procedures as a supportive measure, for all the prisoners involved. Ms Saxon said that she had no plans to self-harm and would talk to staff if she felt upset. Ms Saxon was still being monitored under ACCT at the time.
44. That afternoon, Ms Saxon told the consultant psychologist that she wanted to leave Rivendell House. The psychologist asked her to put her reasons in writing for discussion at their next appointment. He said this might help stop her from making an impulsive decision while feeling emotional.

February 2022

45. On 1 February, Ms Saxon handed in a letter, asking to leave Rivendell House. She said that she might “do something” if her request was not considered. A note was entered in the observation book to alert staff about the comment. She told an officer that she had quit her job. Later that day, she asked the clinical psychologist if she had seen the letter. She was tearful and said she had felt pressured by the consultant psychologist and SO to admit writing the letter to Prisoner A and her decision was final. The psychologist encouraged her to seek support from staff.
46. On 2 February, an officer saw Ms Saxon and Prisoner A kissing in the exercise yard. She told them that while relationships between prisoners were not advised, physical contact was not allowed, and both were issued with a warning. Prisoner A apologised, but Ms Saxon was defensive. Later that day, Ms Saxon told her prison offender manager that she had thoughts of hanging herself when she thought about having to stay in Rivendell House. Staff started ACCT procedures.
47. That afternoon, a SO chaired the opening ACCT review, and an officer, a Custodial Manager (CM) and a nurse from the mental health team attended. Ms Saxon said that she was upset about the way things had developed following the letter to Prisoner A. She felt that the SO and consultant psychologist had encouraged her to confess to writing the letter. She was also upset about being warned about her relationship with Prisoner A. She said that they had a romantic, supportive relationship that was not physical. Staff reiterated that prison rules did not allow physical contact. They asked if there was anything they could do to support her. Ms Saxon said that she regularly spoke to family and friends by telephone and had regular key work sessions. She was also supported by TWP. She said she knew staff were there for her and had no plans to harm herself. Staff agreed to monitor Ms Saxon at least once per hour, and take part in meaningful conversations at least each morning, afternoon, and evening. Ms Saxon was given distraction materials, designed to help prisoners occupy their time when locked in their rooms for long periods.
48. On 3 February, Ms Saxon attended a therapy session with both psychologists and an officer. She was angry and upset, and said that she had been pressured into admitting to writing the letter and had since felt unable to trust staff. She was unsure about leaving Rivendell House but did not want to be near Prisoner B, in whose name the letter had been signed.
49. Staff checked on Ms Saxon in line with ACCT directions. She engaged with them and displayed no behaviour that raised any concerns.
50. On 7 February, Ms Saxon had a therapy session with the clinical psychologist and an officer. Staff noted that she came across as positive and said she felt better about the situation with the letter. She had changed her mind about leaving Rivendell House but wanted to move from the spur she was on as she was still having difficulties engaging with Prisoner B.
51. On 8 February, Ms Saxon was moved to a different spur in Rivendell House.
52. On 9 February, a SO chaired an ACCT review with a nurse from the mental health team and an officer. Ms Saxon said that she was feeling positive and said things

had improved. She had withdrawn her application to leave Rivendell House and said that she wanted to complete the course and that she liked having the support of the staff there. She said that she liked the new spur where she lived and had resumed her job as a cleaner. She said that she had support from her family and had no thoughts of harming herself. The SO explained that because she had had three negative entries, she would be downgraded from the enhanced level of the Incentives Policy Framework. Ms Saxon accepted this and said she wanted to work hard to regain enhanced status. She was aware of what she needed to do to achieve this. All the issues on her ACCT care map had been addressed, Ms Saxon was feeling positive about the future, and all at the meeting agreed that ACCT procedures could be closed.

53. On 14 February, Ms Saxon had a scheduled therapy session with the clinical psychologist and an officer. She said that she had settled on her new spur, her peers were welcoming and there was no atmosphere, unlike on her previous spur.
54. On 16 February, a SO and an officer held an ACCT post-closure review with Ms Saxon. She said she felt better, with no thoughts of harming herself. She felt motivated to complete all her sessions and clinical work and graduate from Rivendell House. She had positive relationships with her peers on south spur but would be happy to explore with staff any issues that she might face. She said that she had felt supported throughout the ACCT process and had addressed her issues.
55. On 20 February, Ms Saxon told an officer that her grandmother had died the previous week. She had not told staff at the time but had dealt with it by going to the chapel.
56. In a therapy session on 24 February, the clinical psychologist and an officer discussed with Ms Saxon the loss of her grandmother. They noted that historically, her risk to herself had increased when she did not ask for support in difficult times. Ms Saxon said that she had not really got on with her grandmother and was not too upset. She did not want to attend the funeral, though would ask to go to the chapel at the time of the funeral. She said that she felt better for talking about it.
57. On 28 February, Ms Saxon told the clinical psychologist that she was having difficulty working with the different types of therapy she was taking part in. She said she was getting herself mixed up and finding it difficult to keep on top of the homework for her sessions but did not want to stop any of the work. They discussed how she could deal with the problem and created a weekly timetable that organised homework around her regular commitments.

2 March

58. On the morning of 2 March, Ms Saxon and Prisoner A were talking in the exercise yard. Prisoner A said that he wished that whoever had written the letter would own up to it. Later that morning, Prisoner A told an officer that he had received a letter from Ms Saxon admitting she had been the author. In the further letter, she said that she had felt their relationship was threatened by Prisoner B. She said that she was sorry and would understand if he did not want anything more to do with her.

59. That afternoon, Ms Saxon handed four letters to the officer. They were addressed to Prisoner A, Prisoner B, another prisoner and to him. She asked him to pass them on. The officer took the letters to the office and read them. In them, Ms Saxon admitted having written the letter on 27 January, and apologised for the events that had followed. He discussed them with colleagues and decided not to pass them on that day so staff could give the situation further consideration. He checked that Ms Saxon was okay. She said that she wanted some time alone, to “let the dust settle”. He asked her if she had any thoughts of harming herself and she said she did not. He said in interview that she showed no signs of increased risk of suicide or self-harm.
60. That evening, Ms Saxon telephoned a friend. She said that she was planning to relax and have a shower the following afternoon after work. She said that she thought she was depressed as she had to “redo all her game again”.

3 March

61. CCTV footage shows that at approximately 7.42am on 3 March, Ms Saxon left her cell and went to collect her medication. She returned to her cell at 7.51am.
62. At approximately 8.00am, at the unit’s morning briefing, staff including an SO, the consultant psychologist and an officer discussed the letters Ms Saxon had handed in the previous day. They reflected that when shared with recipients, there would be consequences for Ms Saxon among her peers, which could increase her risks. She noted that when she had collected her medication that morning, she had spoken to staff and had seemed okay, but they discussed how over the coming days, they would monitor her more closely and provide an increased level of support. They agreed that it was not appropriate for staff to pass the letters on but that they would offer to facilitate Ms Saxon meeting each of the recipients. They would arrange for a member of staff to mediate the conversations so that Ms Saxon could apologise in person.
63. The officer took the letters to Ms Saxon’s cell to explain the decision. He looked into the cell, and she appeared to be kneeling on the floor, facing away from him. He knocked on the door but when she did not respond, he called for colleagues to join him and opened the door. At this point, he saw what he thought could be a ligature and radioed a medical emergency code blue (indicating that a prisoner is unconscious or having difficulty breathing). This prompted the control room to call an ambulance. When he went into the cell, he found Ms Saxon suspended from the window by a shoelace.
64. The officer cut the lace and lowered Ms Saxon to the floor as colleagues arrived. He was unable to detect a pulse or signs of breathing, so he began to perform cardiopulmonary resuscitation (CPR). Ms Saxon began to breathe so staff put her in the recovery position, but he was concerned that she would stop breathing again and continued with CPR until a nurse arrived. CCTV footage showed that the nurse arrived two minutes after the officer entered the cell. More medical staff arrived afterwards and provided medical aid to Ms Saxon. They continued to do so until ambulance paramedics arrived and took over. They transferred Ms Saxon to hospital.

65. An officer was appointed family liaison officer (FLO). She identified Ms Saxon's stepfather as her next of kin and informed him that she had been taken to hospital and was in the intensive care unit.
66. Ms Saxon died at 12.31am on 7 March.

Contact with Ms Saxon's family

67. The FLO remained in contact with Ms Saxon's family while she was in hospital. When Ms Saxon died, hospital staff informed her family. The FLO remained in contact with her family after her death, and in line with Prison Service instructions, New Hall offered a contribution to the costs of her funeral.

Support for prisoners and staff

68. After Ms Saxon was taken to hospital, a CM and one of the prison's managers 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.
69. The prison manager held a further debrief with staff who were with Ms Saxon when she died and signposted them to available support.
70. The prison posted notices informing other prisoners of Ms Saxon'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 Saxon's death.

Post-mortem report

71. Post-mortem tests concluded that Ms Saxon died of a hypoxic brain injury (which meant that her brain was starved of oxygen) due to hanging. No post-mortem toxicology tests were undertaken.

Findings

Assessment of risk

72. Ms Saxon had a history of self-harm and staff at New Hall were consistently responsive to this. They assessed the risks in response to events and offered support and additional monitoring to ensure they could be managed. We found that staff made efforts to consider Ms Saxon's learning difficulty and patterns of behaviour and adapt processes accordingly.
73. Ms Saxon was managed under ACCT procedures on several occasions. On 16 February, at the post-closure review for Ms Saxon's final ACCT, staff reflected that she was feeling positive, moving on from the issues surrounding the letter to Prisoner A, and was fully aware of the support available to her. They concluded that she needed no further ACCT monitoring at that stage and that closure was appropriate. There was no sudden end to the monitoring; unit staff and clinicians continued to offer support on a regular basis after the ACCT was closed.
74. On 2 March, Ms Saxon handed an officer letters, in which she admitted she had falsified a letter to Prisoner A. They referred to how hopeful she was feeling about moving forward. None of the letters indicated any intention to harm herself. The officer considered the risks and addressed them with Ms Saxon. She said she did not feel like harming herself. He concluded that there was no evidence that ACCT procedures should be put in place again. This appears to be a reasonable decision.
75. On 3 March, staff met to discuss the follow up letters that Ms Saxon wrote to prisoners and staff, admitting that she was the author of the original letter to Prisoner A. They considered that the risk of self-harm might increase when the letters were received, and her peers responded to them. They reasonably developed a contingency plan to help mitigate the risks and offered to mediate any follow-up discussions between Ms Saxon and her peers. They did not judge that she needed the immediate support of ACCT procedures at that stage. We are satisfied that without the benefit of hindsight, the decision was reasonable in the circumstances and appropriately based on a multidisciplinary team's detailed consideration of Ms Saxon's risks.

Relationships between prisoners

76. We found an inconsistency between national policy and New Hall's local policy on relationships between prisoners. New Hall's Healthy Relationship Guidance says that intimate or sexual relationships between prisoners are against prison rules. However, the national Prison Service Instruction (PSI) 05/2018 on prisoner discipline procedures says, 'There is no Rule specifically prohibiting sexual acts between prisoners', but staff must be vigilant about inter-prisoner relationships and the risks these can present.
77. When it became clear to staff that Ms Saxon and Prisoner A were in a relationship, they explored this with them in a respectful and sensitive way. Ms Saxon and Prisoner A said that their relationship was not intimate but supportive. Staff provided advice and concluded that there was no evidence that the relationship was coercive or abusive. Nonetheless, the local guidance made it difficult for them to be

confident of the prison's position on the issue and this might create problems in future. We make the following recommendation:

The Governor should ensure that the Healthy Relationship Guidance accurately reflects Prison Rules.

Clinical care

78. The clinical reviewer concluded that overall, the healthcare provided to Ms Saxon was of a reasonable standard and equivalent to that which she could have expected to receive in the community. She found that clinical staff in Rivendell House and in the wider prison were responsive to Ms Saxon's individual needs in the healthcare she was provided, including her personality disorder and her learning disability.
79. However, when ACCT procedures were opened in early February, Ms Saxon's clinical risk proforma should have been updated to ensure staff working with her were fully aware of her risk. The clinical review noted that this did not impact on risk management for Ms Saxon because she was also being supported by ACCT procedures. Had this not been the case, the omission could have left a potentially dangerous gap in her care. We make the following recommendation:

The clinical lead of Rivendell House should ensure that all risk assessments are reviewed when there are concerns about prisoners' raised levels of risk of suicide and self-harm.

Inquest

80. The inquest into Ms Saxon's death concluded on 4 October 2023. The jury provided a narrative verdict and concluded that Ms Saxon took her own life.

**Prisons &
Probation**

Ombudsman
Independent Investigations

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T | 020 7633 4100