**OFFICE OF THE**
**SENIOR CORONER**
for the County of West Yorkshire
(Eastern District)

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Our Ref: DH/JA/1391/16
**Please quote our reference on all correspondence**

2nd March 2018

Ruth Bundey
Messrs Harrison Bundey
Solicitors
Duke House
54 Wellington Street
Leeds LS1 2EE

- 5 MAR 2018

Dear Ms Bundey

**Inquest touching the death of Emily Jayne Hartley (deceased)**

I refer to the recent Inquest which as you know concluded on 1st February 2018 with a Narrative Conclusion. At the conclusion of the Inquest I made Regulation 28 recommendations to both the Head of the Prison Service and the Secretary of State for Health very much along the lines that I did 10 years ago in the Petra Blanksby Inquest.

I enclose a copy of my Regulation 28 report. I will ensure that you are sent a copy of the response when this arrives. You will appreciate though that this will be after my departure on 31st March 2018.

Aside from this may I please state that it has been an absolute pleasure and privilege to me to work with you over the years on what have been some very high profile and complex Inquests. Your dedication to your clients' Inquests and in searching for the truth is highly commendable and it has been a matter of professional pride for me to have been able to assist in any way that I can in this process.

My best wishes to you for the future.

With kind regards,

Yours sincerely

DAVID HINCHLIFF
Senior Coroner
West Yorkshire (Eastern)

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**ANNEX A**

**REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)**

*NOTE: This form is to be used **after** an inquest.*

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| | **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**<br><br>**THIS REPORT IS BEING SENT TO:**<br><br>1. **Mr Michael Spurr, Chief Executive National Offender Management Service, 7th Floor, Clive House, 70 Petty France, London, SW1H 9EX**<br>2. **Rt Hon Jeremy Hunt, Secretary of State for Health, Department of Health, Richmond House, 79 Whitehall, London, SW1A 2NS** |
| 1 | **CORONER**<br><br>I am David Hinchliff, Senior Coroner, for the Coroner area of West Yorkshire (East) |
| 2 | **CORONER'S LEGAL POWERS**<br><br>I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013. |
| 3 | **INVESTIGATION and INQUEST**<br><br>On 26th April 2016 I commenced an investigation into the death of Emily Jayne Hartley age 21. The investigation concluded at the end of the inquest held on 15th January 2018 until 1st February 2018 before a Jury. The conclusion of the inquest was in narrative form, a copy of which is attached. |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br><br>Emily Jayne Hartley was a serving prisoner at Her Majesty's Prison New Hall. On Saturday 23rd April 2016 Emily was allowed out of the confines of the winged building for exercise. She was recorded as being on exercise at 15:00 hours that day, yet CCTV material shows that she left the wing at 14:24 hours with other prisoners. They left the wing through the main wing entrance door and were on exercise. The exercise area extends to the rear of the winged building which is itself a large detached two story block with a grassed area at the rear surrounded by a high perimeter fence. There was a part of this area declared to be "out of bounds" and Emily would have been aware of this. Nevertheless this area can be easily accessed. Once exercise is complete the prisoners should be counted back onto the wing. At 16:45 hours staff realised that Emily had not collected her meal and she could not be found. It was apparent that Emily had not returned to the wing. At 16:50 hours following a perimeter check Emily was located suspended from a torn piece of bed sheet fastened to a steel security gate in a recessed area in the out of bounds section. Emily was cut down, CPR was commenced by prison staff which was continued when Paramedics arrived. Her death was confirmed by Paramedics at 17:43 hours at that location.<br>Emily was the subject of an ACCT plan (assessment, care in custody and team work) and should have been observed at twice per hour intervals. Emily had mental health issues and suffered from an emotionally unstable borderline personality disorder which made her impulsive and prone to self-harm and suicide. Concerns were expressed that the management of self-harm and suicide procedures, in particular the monitoring and recording were seriously deficient and that some of the noted failings were systemic. Information sharing was weak, there was a lack of integrated planning. The supervision of Emily when she died and whilst on Suicide prevention was so poor that she was not found for nearly two and a half hours. There were allegations of bullying when she was on a wing designated as being a therapeutic setting. |

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| 5 | **CORONER'S CONCERNS**<br><br>During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you.<br><br>The **MATTERS OF CONCERN** are as follows. –<br><br>(1) It became apparent from the evidence of many Prison Officers and Healthcare Workers that Prison was not the appropriate environment for someone with Emily's mental health problems. The emphasis should have been on treatment but within a secure environment which Prison, with the most well intentioned staff, cannot adequately provide.<br><br>(2) Coincidentally ten years ago I heard an Inquest into the death of Petra Blanksby, also at New Hall Prison. At the conclusion of this Inquest I made a recommendation pursuant to what was then Rule 43 of the Coroner's Rules 1984. I attach a copy of my Rule 43 recommendations which I repeat in every detail in respect of the death of Emily Jayne Hartley. Furthermore I state that a Prison is not the appropriate place to accommodate Emily and that there should be facilities, particularly in the Prison's female estate, to provide a therapeutic yet secure environment with the emphasis being on treatment.<br>I repeat ten years later that the Prison's department and the Department of Health should conduct a collaborative exercise to achieve the provision of suitable, secure, therapeutic environments in order to treat those with mental health problems of the nature of those demonstrated by Petra Blanksby ten years ago and now Emily Jayne Hartley. I would refer you to a paper prepared by "Inquest" entitled Preventing the Deaths of Women in Prison and the Need for an Alternative Approach which was published in June 2013 and also a report by Baroness Jean Corsten of a review of Women with Particular Vulnerabilities in the Criminal Justice System. |
| 6 | **ACTION SHOULD BE TAKEN**<br><br>In my opinion action should be taken to prevent future deaths and I believe that your organisation have the power to take such action. |
| 7 | **YOUR RESPONSE**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by 27th April 2018. I, the Coroner, may extend the period.<br><br>Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed. |
| 8 | **COPIES and PUBLICATION**<br><br>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons:-<br><br>Ruth Bundey of Harrison Bundey Solicitors<br>Katrina McCrory of Mills & Reeve Solicitors<br>Elaine Marshall of A2 MOJ Private Law Litigation<br><br>I am also under a duty to send the Chief Coroner a copy of your response.<br><br>The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner. |

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| 9 | 2nd March 2018 |

## NARRATIVE CONCLUSION

The Jury have found that Emily Jayne Hartley hanged herself on 23 April 2016 and was pronounced dead at 17:34 in an external out of bounds area of New Hall Prison.

The Jury believe that at the time of sentencing, New Hall Prison was an appropriate place of detention. However, due to the deterioration of Emily's mental state from January 2016, with an increase of self-harm and suicidal ideation, this should have been reviewed by all parties and a move to a therapeutic unit would have been more appropriate. This move would have increased the focus on the medical element of Emily's situation. Fully trained, focused staff would have ensured that the increase in mirtazapine that had been prescribed would have taken place. In addition, the medical staff would have been more knowledgeable on EUPD than disciplinary staff, who we believe did not have sufficient training and therefore understanding of the condition.

For a critical and particularly vulnerable time that Emily's mental health deteriorated, she was left without a named nurse, seeing various health care workers in approximately two weeks. Given Emily had abandonment issues this was felt to have had an impact on her well-being and left room for miscommunication.

The discovery of a file with a suicide note at a time of attempted ligature on 15 April 2016 should have triggered an immediate ACCT review [PSI 64/2011] to ensure that Emily's welfare was attended to. At a time when she was in crisis, this immediate review was not undertaken despite a Case Conference having been held with other mental health staff. The sharing of the information of the existence of this file was unsatisfactory. All staff coming into contact with Emily should have been made aware of the severity of Emily's situation, as she posed a "significant risk to herself".

The majority of the Jury do not believe that Emily was bullied by Holly Ward staff. However, for some officers, we have concerns for the professionalism that we would have expected from people fulfilling the roles, was not consistently good and that Emily could have perceived this was bullying. This lack of professionalism was demonstrated by the contradictory evidence of the events of 19 April in which it is logically clear that fictional accounts were given under oath as the accounts are mutually exclusive.

This lack of professionalism of some officers extend to the implementation of the ACCT process. Whilst we can empathise with the difficult and demanding job Prison staff have rigorous adherence to the ACCT process should be paramount. The failure to apply the ACCT process as intended was a key contributing factor to Emily's death.

We believe the policy of cumulative entries on the ACCT record of itself did not contribute to Emily's death. However, the lack of meaningful physical checks, especially on 22 April 2016, contributed to the increased deterioration of Emily's mental health. It is the Jury's belief that this was a key factor leading up to the events that occurred thereafter.

The absence of meaningful observations and accurate recording in the ACCT file at times on 22-23 April 2016 demonstrate that some Prison staff did not give the ACCT process sufficient importance that it requires and failed to abide by ACCT protocol.

The Jury believe that the exercise area used for Oak inmates was inadequate and not fit for purpose. A risk assessment should easily have identified that inmates had the potential to disappear from view, especially when only one disciplinary staff were allocated to manage the exercise session.

The Jury would like to also note additional issues that arose from this inquiry.

First, the Jury wishes to highlight deficiencies in the external CCTV and also the lack of internal wing CCTV, both of which could have aided in the help of locating Emily Hartley sooner. Secondly, given Emily's ligature history it is our belief someone who poses such a risk to themselves should only be issued anti-ligature bedding, especially considering someone who is in crisis or with complex mental health issues.

As a last note, the Jury would like to express our compassion towards the family of Emily given the failings in releasing evidence by West Yorkshire Police.

**West Yorkshire**
**Coroner's Court**

**Inquest into the death of Petra Blanksby**

**Rule 43 Recommendations:**

I have recently concluded an Inquest into the death of the above named in my Wakefield Court before a Jury. This Inquest was held over a 3-week period from 14th January to 1st February 2008.

The Jury recorded a unanimous narrative verdict in the following terms:

> ''Petra Blanksby died from 1(a) Hypoxic Brian Damage due to (b) Ligature Strangulation
>
> On or around 11.40am on the 19th November 2003 in New Hall Prison, Wakefield she asphyxiated herself by ligature. This resulted in her ultimate death in Pinderfields Hospital Wakefield at 11.35 am on 24th November 2003.
>
> Traumatic life experiences including mental and physical abuse in early childhood, coupled with an unstable upbringing and a complete lack of emotional support.
>
> Prison was not an appropriate place in view of Petra's diagnosis.
>
> There appears to be no infrastructure in the forensic Mental Health Service for people with her problems.

At the conclusion of this Inquest I made an announcement pursuant to Rule 43 of the Coroner's Rules 1984.

It might be helpful for you to have a brief overview of some of the important issues raised at the Inquest. Petra Blanksby was received into prison on 9th July 2003, charged with arson with intent to endanger life. This rose from Petra having tried to set fire to herself by way of an attempt at suicide, but this caused her accommodation to catch fire. Her motive was not that of destruction or deliberate fire raising. At the time Petra was aged 19 she was a single mother of a baby boy aged 18 months. Se had complex mental health problems. At the time her child was under the care of Derbyshire Social Services.

Petra had a long history of self-harm and at the time of the offence was receiving support herself from social workers, and a community psychiatric nurse. Petra was suffering from a personality disorder; she was always regarded as being at high risk of self harm , and there had been countless occasions when she had cut herself, attempted ligature strangulation, set herself alight, she had inserted objects into her body through wounds, and had taken several overdoses of tablets.

For the whole of the time that she was at New Hall Prison she was subjected to the Form 2052 self-harm monitoring procedure. I heard evidence that in the 130 days that

Petra was in prison there were 90 incidents of self-harm. On two occasions she had to be transferred to an outside hospital for treatment. Notwithstanding this Petra was popular with both staff and fellow prisoners, who had considerable regard and affection for her.

Petra had been diagnosed prior to her admission to prison as having an emotionally unstable personality disorder. This raised issues as to whether or not she cold be detained under the Mental Health Act 1983. The rationale for not detaining her was that it would only have been appropriate to detain her under Section 3 of that Act, as opposed to Section 2, which is for assessment. The only class of mental disorder from which she was suffering was ''psychopathic disorder'', and to be detained under Section 3 would be necessary to show that she was treatable. According to the psychiatrists responsible for her care this criteria was not met. It was thought that she might benefit from psychotherapy, but was not ready to reside in a therapeutic community as she was taking medication, was too chaotic and her risk of self harm was too high. Notwithstanding this no suitable facility could be found.

The Inquest heard that Petra was at very high risk of killing herself, whether she was in the Prison Health Care Centre or an ordinary location, or in a psychiatric hospital in the community. Notwithstanding that her care in prison was regarded as satisfactory. It was abundantly clear that prison was not the appropriate place for a young lady with Petra's complex problems, but because of her diagnosis of a psychopathic disorder there were no ground for transferring her to hospital for treatment under Section 48 of the Mental Health Act 1983. Petra was typical of prisoners with mental health disorder who politicians and those who campaign say should be in hospital rather than prison, yet there is no way of achieving this.

It must be that in a civilised society someone as severely mentally disordered as Petra should have been in the care of ordinary or forensic psychiatric services, and not in prison.

The point of my contacting both the Prison Service and the Department of Health is to urge, by virtue of this recommendation, that the two departments work together to achieve a situation where suitable, secure, therapeutic environments outside prison can be available for those like Petra, suffering from such disorders.