

**The Death in Custody of
a woman at
HMP Eastwood Park in June 2005**

**Report by the Prisons and Probation Ombudsman
for England and Wales**

June 2006

This is the report of an investigation into the circumstances surrounding the death of a woman at HMP Eastwood Park on 4 June 2005. The woman was 28 years of age. Her cause of death was mixed drug toxicity (her death occurring as a result of the interaction between the prescribed medication and non-prescribed drugs that she had taken).

The investigation was carried out by two of my colleagues. A review of the woman's clinical care and treatment was carried out by a doctor from South Gloucestershire Primary Care Trust. A review of the woman's detoxification programme was carried out by a nurse consultant in substance misuse from the women's prisons health team in Prison Health.

Nothing emerged during this investigation to indicate that the woman might have been thinking of harming herself. It would seem that that her death through overdose was entirely accidental.

I extend my sincere condolences to the woman's family for their loss. I would like to thank the Governor of Eastwood Park, and his staff for their help during this investigation.

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Prisons and Probation Ombudsman

June 2006

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SUMMARY

In recent years the woman had become used to occasional periods in prison custody. Her convictions tended to be for offences such as theft and handling of stolen goods, and her prison sentences were for fairly brief terms. The woman had a long history of drug abuse.

The woman was known to many of the staff at Eastwood Park. From interviews with some of those staff, the woman emerges as a bright and happy person who coped well with her periods of imprisonment. However, her records from previous times in Eastwood Park show that she would obtain and take illicit drugs while in custody.

The woman was received into Eastwood Park for the final time on 31 May, having received a sentence of eight months for a variety of offences including theft and a number of driving related matters. On arrival at Eastwood Park, the woman reported that she was taking prescribed benzodiazepine. She also declared that she was using heroin and cocaine/crack cocaine. A urine test proved positive for both those drugs, but negative for all other drugs tested for. Following examination, the woman was prescribed methadone for opiate detoxification and diazepam for detoxification from benzodiazepines. The woman was located in a room in the prison's detoxification unit.

Nothing of significance occurred on 31 May, and nor in the following days. The woman seems to have settled into the prison routine and she was reported to have been laughing and joking with staff. One of the nursing staff wrote a report following the woman's death to say that the woman had reported feeling better than usual. She also thought that she was looking healthier than usual.

The officer who locked the woman into her room at 8pm in the evening on 3 June, said that the woman was her usual self at that time.

At just after 9am on the morning of 4 June, staff began to unlock rooms for prisoners to have their medication. The woman's room was unlocked and an officer went in to wake her. When the officer touched the woman's leg to rouse her, she found that her leg was cold. The officer called out for assistance, but on examination it was clear that she had been dead for some time.

On 5 June, a prisoner reported to an officer that the woman had obtained some amitriptyline from another prisoner on 3 June. Presence of that drug was found in the woman's blood upon toxicological examination after her death. In the post mortem report the pathologist, explained that the co-administration of diazepam and amitriptyline with methadone can substantially increase the likelihood of serious toxicity. In the presence of these other drugs, a normal or usual dose of methadone can prove fatal. In conclusion, the pathologist found that the woman's cause of death was mixed drug toxicity.

Nothing has emerged in this investigation to indicate that the woman had had any intention to harm herself deliberately. I think the most likely explanation is that she died as a result of an inadvertent overdose.

I have made recommendations about Eastwood Park's contingency plans. I have also made a recommendation about procedures for notifying next-of-kin about deaths in prison custody. My report also contains a number of recommendations from the two clinical reviews relating to the clinical care and treatment of prisoners undergoing detoxification. These latter recommendations should be considered by Prison Health to see whether they indicate a need to change national detoxification policies and procedures.

INVESTIGATION PROCESS

The investigation was opened on 7 June 2005 when one of my investigators visited Eastwood Park and was given access to the woman's records. Notices were issued concerning the woman's death and were displayed around the prison.

My investigator spoke with the local branch of the Prison Officers' Association (POA). He also met a member of the Independent Monitoring Board (IMB) and sought her views on the prison in general and the woman's death in particular.

Formal interviews were conducted with staff and a number of prisoners.

One of my Family Liaison Officers spoke with the woman's father by telephone. He said that a female member of prison staff told him that his daughter had left her cell light switched on all night on the night of her death. The woman's father said that if his daughter's light had been left on why had staff not checked to see how she was, especially given that she was going through detoxification.

The woman's father said that her family had not known that she was back in prison and the way in which his wife was informed of her daughter's death had been devastating. A family liaison officer from the local police force had visited the family home with a message to telephone the prison. When his wife did so, she was told that her daughter was dead.

The woman's father said that the family were also upset by the fact that the BBC internet site stated that the woman had hanged herself. He wanted to know whether it was the Home Office Press Office that released this incorrect information.

HMP EASTWOOD PARK

Eastwood Park is a women's local prison located in Gloucestershire. The prison opened in 1996 and can hold around 350 prisoners.

Eastwood Park has a diverse regime offering courses in catering, horticulture, hairdressing, hygiene and beauty. It also offers sports leader and other sports awards; Job Clubs; offending behaviour programmes and educational courses ranging from basic literacy and numeracy to Open University post graduate degrees.

Eastwood Park has 24 hours healthcare provision. Many of the women coming into the prison have a history of drug use. Prisoners with a drug problem are identified by a variety of means including initial reception screening by healthcare staff, observations by other staff and self-referrals. Arrangements for detoxification, rehabilitation, treatment, education, and counselling, include educational classes which are run by the Bristol Drugs Project and Narcotics Anonymous.

THE EVENTS LEADING UP TO THE WOMAN'S DEATH

On 21 March 2005, the woman was convicted of theft and remanded into Eastwood Park. The woman remained in Eastwood Park until 3 May, when she was released on bail while awaiting sentencing. On 31 May, the woman was sentenced to eight months' imprisonment and returned to Eastwood Park.

On her arrival at Eastwood Park on 31 May, the woman saw a reception nurse who recorded that the woman had a continuing drug habit, using heroin and crack cocaine. A urine test proved positive for both of these drugs, but was negative for benzodiazepines as with all other drugs tested for. The form onto which the reception nurse entered this information is entitled: '*Further Reception Health Screen Checks*'. The reception nurse said at interview that her practice was to carry out the abbreviated version of the health check when the person had only been out of prison for a fairly brief period of time. In the woman's case, the reception nurse thought that she had only been out of prison for around 10 days.

After she had been seen by the reception nurse, the woman was then seen by a doctor whose record of the consultation included:

"... [past medical history]: nil of clinical interest.

" ...

"Drugs: Heroin addict.
 [Benzodiazepines] prescribed ...
 Crack/cocaine.

"Impression: Not first time prisoner. Detoxed recently but went back using post release. No suicidal ideation. No [history] of [deliberate self harm]. Feels well in self although drug withdrawal symptoms. Fit for [detoxification unit]. [Review] if needed."

The woman was prescribed methadone for detoxification from heroin and she was prescribed diazepam for detoxification from benzodiazepines.

On 1 June, the woman was seen by the detoxification nurse for a review of her detoxification programme. The woman said that she had no problems, she understood the detoxification programme from having done it before and everything was fine. The detoxification nurse knew the woman from previous times she had been in Eastwood Park. She described the woman as a nice person, a bubbly person who got on with other prisoners.

In the late afternoon of 3 June, The woman would have had her evening meal at around 6pm and would have had her last medication of the day at around 7pm. She remained out of her room on association until lock-up time. The

detoxification nurse had seen the woman during that evening when she had been her usual self and had been laughing and joking.

The staff nurse also said that the woman had been laughing and making sarcastic comments to the nursing staff on the evening of 3 June. She said that the woman was well known to the staff at Eastwood Park; she was usually quite jovial and was a very pleasant person to have in the detoxification wing. Following the woman's death, the staff nurse wrote a statement about the woman's demeanour on 3 June. The statement mentioned that the woman reported feeling better than she usually did when going through detoxification. The woman also said that she thought she was looking healthier

The first officer knew the woman from previous times in Eastwood Park. The first officer said that the woman had a lively personality and was an easy person to talk to. On this last occasion, the woman appeared no different to usual. On 3 June, the woman was her normal self. She was exchanging banter with staff and laughing right up to the point that the first officer locked her into her room at 8pm.

The first night officer said that the woman could be loud and demanding, but she was never a problem. The first night officer said that there had been one night earlier that week when the woman had asked for a Listener (a Listener is a prisoner trained by the Samaritans to listen to and support other prisoners). There had been no Listeners available that night, so the first night officer offered the woman the Samaritans' telephone number which the woman refused to take. Ten minutes earlier, the woman had been asking for cigarette ends so the first night officer assumed that the woman wanted a Listener so she could ask for a cigarette – like many other prisoners, the woman would ask for cigarette ends or would ask the Listeners for cigarettes once she had used up her own supply. The first night officer had never known the woman to need the support of a Listener, and there had been nothing about the woman's demeanour that night or at any other time to cause the first night officer any concern.

The first night officer said that many women tend to sleep with their room lights or televisions switched on. She could not recall the woman's practice.

On the night of 3 June, the first night officer started a shift at 8.15pm. She and the second night officer counted the prisoners in A, B and C wings. The first night officer could not recall whether it was she or the second night officer who counted the prisoners in B1 (where the woman was located). She said that the usual practice was for the two officers on duty to share the counting, although it was often the case that just one of the two officers would sign for all of the prisoners counted.

The second night officer described the woman as a confident person who would have been unconcerned about coming back into prison. He said that many of the women sleep with room lights or televisions switched on, but he could not recall whether the woman did so. The second night officer said that nothing had occurred on the night of 3 June or the morning of 4 June to cause him any concern. He could not recall whether it was he or the first night officer who counted the prisoners in B1, although the first night officer was certain that it was

the second night officer who carried out the entire count on the morning of 4 June.

SECURITY REPORT FOLLOWING THE WOMAN'S DEATH

On 5 June, a prisoner reported to a member of staff that the woman had taken amitriptyline on the night of 3 June. She said the woman had obtained the drug from another prisoner. At interview with my investigator the prisoner said that she had known the woman for around six years. The woman was a bubbly person who got on well with prisoners and staff and who would never wish to deliberately harm herself. However, the woman was also someone who would take illicit drugs if she could, and would take those in addition to her prescribed medication. The prisoner added that many of the women in Eastwood Park would do the same and would take illicit drugs without even asking what the drugs were.

The prisoner said that the woman had taken the amitriptyline before lock-up on the evening of 3 June. At around 7.15pm, the woman had been lying on her bed. The prisoner described the woman as 'wrecked'. The prisoner had not believed that the woman was in any danger and so she had not thought there was any reason for her to speak to staff.

THE DISCOVERY OF THE WOMAN'S DEATH

Before going off duty at 7.30am on the morning of Saturday 4 June, the night officers would have counted the prisoners, although they would not have obtained responses from them. The day staff would also have carried out a count on their arrival, but again they would not have obtained responses from prisoners.

At around 9.10am to 9.15am, the second officer unlocked the woman's door for her to receive medication. The second officer went into the room and touched the woman's leg to wake her. The woman's leg was very cold. When the second officer shook the woman's arm that was cold too. The second officer shouted for assistance and the staff nurse, who was nearby, came into the room. After a further unsuccessful effort to rouse the woman, the second officer sent out a Code Blue alarm, timed as being issued at 9.20am (a Code Blue alarm indicates that a prisoner has severe breathing difficulties and support is needed from healthcare and senior staff).

The staff nurse said that it was at around 9.10am to 9.15am when she heard staff shouting for assistance and she went to the woman's room. The woman was lying in the foetal position. The staff nurse moved the woman's hair to check for a ligature, but found none. She then checked for presence of a pulse. With the second officer, the staff nurse tried to move the woman on to her back so she could commence CPR (cardio-pulmonary resuscitation). However, as well as being cold, the woman's body was also very stiff. It was clear that she was already dead. The staff nurse and the second officer agreed that a Code Blue alarm should be issued at around this stage. Healthcare staff arrived with emergency equipment and the senior officer also arrived. The staff nurse said she became upset so the senior officer took her out of the room.

At interview, the senior officer said that on hearing a Code Blue alarm at about 9.20am, he ran to unit B2 and went into the woman's room. The senior officer said he checked whether there was a ligature around the woman's neck. There had been some material loosely around her neck so the senior officer cut it away with his anti-ligature knife. When asked at interview whether the material had indeed been a ligature rather than just the woman's clothing entangled around her neck, the senior officer said that he had not concentrated on the material itself, and whether it was or was not a ligature. He was concentrating instead on saving the woman's life. Once he had cut away the material, the senior officer's intention, as a person trained in first-aid, was to attempt resuscitation. With the second officer's assistance, the senior officer turned the woman onto her back and it was then obvious that she was dead – she was cold and rigor mortis had set in. The senior officer estimated that the woman had died at least eight hours earlier. The senior officer said that he was aware that instructions to staff state that resuscitation should be attempted when a prisoner is discovered not to be breathing, and that such attempts should continue until a doctor has pronounced death. Despite those instructions, the senior officer was clear that attempts at resuscitation would not have helped the woman. The senior officer radioed through to the communications room to ask for an ambulance to be summoned.

He also requested the attendance of senior staff – the duty Principal Officer and duty Governor.

The acting primary care manager, who is a highly experienced nurse, arrived at the point that the senior officer was cutting material away from the woman's neck. The acting primary care manager said that, when she examined the woman, it was clear that she was dead.

The ambulance service was contacted at 9.32am and ambulance paramedics arrived at 9.51am. The notes made by the paramedics included:

“... [patient] found with rigor mortis [and] hypostasis (settling of blood to the lower part of the body following death).”

AFTER THE WOMAN'S DEATH

The Duty Governor responded to the call for the attendance of senior staff after the discovery of the woman's death. The Duty Governor liaised with the local police who had attended the prison and who said that they would arrange for colleagues from Cardiff police to visit the family home to break the news in person.

Later on, the Duty Governor received a telephone call from the woman's mother. She said that a police officer had arrived at her home and had given her a message that she should telephone Eastwood Park but she did not know why she had been asked to do so. The Duty Governor then informed the woman's mother of her daughter's death.

Eastwood Park subsequently sent a letter of condolence, an offer for the family to visit the prison and an offer of assistance with the funeral expenses.

When interviewed, the Duty Governor said that she did not know whether or not the woman's room light had been left switched on throughout the night. She added, however, that many of the women at Eastwood Park slept with their room lights switched on.

EASTWOOD PARK'S CONTINGENCY PLANS

As with all prisons, Eastwood Park has contingency plans detailing how staff filling various roles should deal with certain situations. The contingency plan for the first staff at the scene in the case of a serious clinical incident (but which is actually titled 'Death in Custody'), includes the following instructions:

"Raise the alarm and summon medical assistance ...

" ...

"Clear airway and always attempt resuscitation ..."

The contingency plan for healthcare staff includes:

"Advise control to call for an ambulance if required."

During interviews with staff, a degree of inconsistency emerged in terms of their understanding of who is, or should be, able or responsible for requesting that a 999 call be made to summon a response from the ambulance service.

However, staff were unanimously of the view that a Code Blue alarm should not automatically trigger a 999 call. Their reasoning for this was that there are many incidents at Eastwood Park of prisoners being found with ligatures around their necks, in addition to incidents of harming themselves by other means. Both discipline and healthcare staff said that they were able to deal with the vast majority of these cases without assistance from ambulance paramedics.

The communications room officer did not complete the communication officer's log of events. In discussion with the investigators, he said that the contingency plan is entitled 'Death in Custody' and he would only use the form if he knew that the prisoner was dead at the time of him being contacted.

THE WOMAN'S CAUSE OF DEATH

The story of the ligature

Following the woman's death, staff were asked to write statements about their actions on the day. This is standard Prison Service practice. In his statement, the senior officer described finding a ligature that he cut away. This information was included in the report submitted to the Prison Service's National Operations Unit. The Prison Service's Press Office was notified leading to a statement being released to the media. The story was then published by the BBC on its news website.

When the senior officer was interviewed for this investigation, he said that when he responded to the emergency alarm his imperative had been to try to save the woman's life if at all possible. There had been some material around her neck so he cut it away.

No signs of strangulation were found when the woman was examined at post mortem. The police confirmed that the material that had originally been described as a ligature was simply the woman's clothing that had become entangled around her neck.

Toxicology and post mortem findings

Toxicological investigations found presence in the woman's body of methadone, diazepam, diethylmethyldiazepam, nortriptyline and amitriptyline. Amitriptyline was not a medication that the woman had been prescribed, it was a drug that she had taken illicitly.

In reviewing the toxicology findings, the pathologist explained in his post mortem report that co-administration of diazepam and amitriptyline with methadone can substantially increase the likelihood of serious toxicity. In the presence of these other drugs, a normal or usual dose of methadone can prove fatal. The pathologist found that the woman's cause of death was mixed drug toxicity.

FINDINGS AND CONCLUSIONS

The woman was a long term user of heroin who had served several prison terms in recent years. Her sentences were all for brief periods and all were in respect of comparatively minor offences. From the interviews with staff, the woman emerges as a cheerful, lively and confident individual. She seems to have got on well with staff and other prisoners and seems to have coped well with prison life.

The woman was convicted of theft on 21 March 2005 and was remanded into Eastwood Park awaiting sentencing. The woman was released on bail on 3 May, but was returned to Eastwood Park on 31 May upon being sentenced. Because the woman had been out of prison for only a comparatively brief period of time, the reception nurse did not undertake the First Reception Health Screen process. Instead, she incorrectly followed the abbreviated Further Reception Health Check process that should only be used following very brief periods out of prison, such as a remand court appearance. On this form, the reception nurse recorded the woman declaring a continuing heroin habit with occasional use of crack cocaine. A urine test proved positive for both drugs.

After being seen by the reception nurse, the woman was then seen by one of the prison doctors who also recorded that the woman used heroin and crack cocaine. In addition, the doctor recorded that the woman was taking prescribed benzodiazepines. The doctor prescribed methadone for opiate detoxification and diazepam for benzodiazepine detoxification.

On 1 June, the woman was seen by the detoxification nurse. The woman said that she had no problems and understood the programme as she had been through it before.

The remainder of 1 June and the following two days proved equally unremarkable for the woman, with all of the evidence showing that she settled happily into prison routines. In her interview, the first night officer said that on one evening in that week the woman had asked for a Listener. However, no Listeners were available and the woman refused the offer of the Samaritans' telephone number. The first night officer thought that the woman probably wanted to see a Listener so she could get a cigarette. From all that I have discovered about the woman, I have no reason to believe that she was in need of emotional support that evening. The first night officer's theory seems far more probable.

On the evening of 3 June, the woman was locked into her room at around 8pm. According to the first officer, the woman was her usual jovial self up to that point in time. The night officers started their shift at 8.15pm and they carried out a count. This was the last time that the woman was observed alive.

On the morning of Saturday 4 June, staff began unlocking rooms at just after 9am for prisoners to receive their medication. The second officer unlocked and went into the woman's room and tried to wake her. The woman was lying in the foetal position. She was unresponsive and her body was cold. The second officer shouted for assistance and the staff nurse responded. She examined the

woman and found that she had no pulse and that her body was both cold and stiff. The second officer issued a Code Blue alarm for a response from healthcare and senior staff.

The senior officer responded to the Code Blue. He checked the woman for presence of a ligature and cut away some material that was tangled around her neck. When the senior officer tried to turn the woman on to her back, he realised that rigor mortis had set in. Although Eastwood Park's contingency plans state that resuscitation should always be attempted, the senior officer was clear in his mind that the woman had been dead for some hours and that it would have been inappropriate to attempt resuscitation. I consider the senior officer's decision in this respect to have been entirely appropriate. Indeed, Prison Service Order (PSO) 2700 states that attempts at resuscitation need not be made where rigor mortis has clearly set in.

For some time, the cause of the woman's death remained unclear. The pathologist's report has now revealed that the woman died from mixed drug toxicity arising from the interaction of prescribed medication with illicit drugs. A prison intelligence report dated 3 November 2004, when the woman was a remand prisoner at Eastwood Park, refers to an incident when she was found in possession of heroin and cocaine that had been passed to her by a visitor. On 18 November 2004, another intelligence report referred to the woman's appearance and behaviour as being suggestive of drug use. From this, it would seem that the woman would try to obtain illicit drugs while in prison. Indeed, on 5 June, a prisoner reported to an officer that the woman had taken amitriptyline on the evening of 3 June. At interview with my investigator, the prisoner said that the woman took these drugs before lock-up, and that at about 7.15pm she was lying on her bed 'wrecked'. However, this does not accord with the evidence given by staff, including the first officer who locked the woman into her room at 8pm. Staff, many of whom knew the woman from previous times in Eastwood Park, described her as being her usual self that evening. She had been out and about on the wing, laughing and joking and bantering with staff, right up to the point of lock-up at 8pm. An explanation for the discrepancy may be that the prisoner was anticipating the woman's likely condition once she had taken those drugs after lock-up.

There is no evidence to suggest that it had been the woman's intention to harm herself. She was described consistently as a happy-go-lucky person who got on well with everyone and had no problems coping with prison life. I have no reason to believe that the woman appreciated the danger she was in. Nor did the other prisoner.

I remain confused about the timing of some of the events on the morning of 4 June. It would seem that the woman was found at around 9.10am to 9.15am. However, although statements from staff indicate that the Code Blue alarm was issued at approximately 9.20am, an unsigned catalogue of events shows the Code Blue alarm as being issued at 9.31am and the call to the ambulance service being made at 9.32am. It is clear from the descriptions given by staff and from the records made by the ambulance paramedics that the woman had been dead for a considerable amount of time when she was found. It was also clear

from their interviews that most of the staff involved in the events of that morning liked the woman and were distressed by her death. If there were any delays in the response from staff it would have had no impact on the outcome for the woman. However, in other circumstances delays might be critical.

Attempting to resolve the timing of events that morning is not helped by the fact that the communications officer did not fill in the relevant page of the contingency action plan. His explanation for not doing so was that the plan is entitled 'Death in Custody' and is therefore only completed when the duty communications officer knows that the prisoner is dead. However, no prisoner is officially 'dead' until they have been declared such by a doctor. I have made a recommendation relating to all staff who work in the communications room being reminded and/or retrained about their role in an emergency situation.

A degree of inconsistency was found during staff interviews about who should summon a response from the ambulance service. Eastwood Park's contingency plans indicate that it is healthcare staff who make the decision whether such support should be summoned. However, the senior officer was of the view that any member of staff should be able to call for an ambulance if they believe one is needed. This seems to me to be both sensible and pragmatic and in line with the Department of Health guidance issued to prisons in March 2004.

The woman's family were concerned about the way in which they were notified of her death. The woman's mother had no family members with her when she received a message from the police to telephone Eastwood Park, and it was by telephone that she heard the news. A breakdown in communication had caused this problem. The intention had been for the Gloucester police to liaise with their counterparts in Cardiff and to ask for two officers from that force to inform the woman's family of the sad news in person. It is not unusual for a visit to the family to be made by officers from the police force local to the family home, and I can understand why staff at Eastwood Park accepted the offer from the Gloucester police that they would contact the Cardiff police. However, by using this method, Eastwood Park lost control of the process.

The supplementary guidance to PSO 2710, which deals with the follow-up to deaths in custody, recommends that the prisoner's family should be informed face to face as soon as possible after the death. Wherever possible, this should be done by appropriate staff from the prison. If this option presents a problem, appropriate prison staff in the area nearest the family home could be asked to visit. Asking the police to inform the family should be considered only after initially assessing the other options. In the woman's case, it would have been better practice to have asked staff from Cardiff prison to visit the family to break the news.

The woman's family found it upsetting that the BBC news website stated that the woman had been found with a ligature around her neck, when it later transpired that it was merely the woman's clothing that had become entangled around her neck. I understand why the woman's family found this distressing. This would be the case for any family. However, I am satisfied that all Prison Service staff and agencies involved acted in good faith and that no criticism is warranted.

FINDINGS AND CONCLUSIONS OF THE CLINICAL AND DETOXIFICATION REVIEWS

The clinical reviewer's findings and conclusions

1. I would like to congratulate the prison for the quality of reports provided by each member of the team who was involved with the woman's sudden death on 4 June 2005.
2. All records have been completed during this and previous prison sentences, which has facilitated this investigation.
3. Clinical management of the woman was followed according to present protocols for an admission to the unit and detoxification. All medical records have been completed and signed including dispensed medication.
4. In the Incident book there were supportive comments given for all those who were involved with the woman's care and the prayer in recognition of her sudden death. I thought this was excellent practice.
5. Cause of death was due to mixed drug toxicity. It would be prudent for the prison to review their protocols for the dispensing of Methadone and diazepam in the light of the Coroner's report. Also to review the control of illicit drug trafficking within the prison.

The detoxification reviewer's findings and conclusions

While there was an inadequate assessment of the woman's substance misuse upon her return to prison on 31 May, it would appear that her opiate withdrawal was adequately managed, although formal evidence of this is lacking, as there was a failure to undertake the withdrawal/intoxication monitoring.

Whether or not the woman required the level of Diazepam prescribed, when dependency is not demonstrated from the recorded assessment, and negative urine drug screen on arrival, is less clear. The woman had been prescribed both these regimes simultaneously during her previous admission, with no untoward events having been noted. It is likely therefore, that these regimes would have progressed without incident on this occasion were it not the fact that post mortem findings confirm that the woman then took additional illicit medication on top of the prescribed regimes.

Methadone and diazepam both have the potential to cause respiratory depression, and when given in combination this risk increases. The simultaneous prescribing of these two regimes is common place in women's prisons, and is undertaken cautiously, in small divided doses, with modest routine upper limits, in recognition of this. Formal withdrawal/intoxication monitoring offers further protection, with doses of sedating medications being withheld immediately if there are signs of drowsiness or collapse. As previously

described, failure to treat benzodiazepine dependence brings with it life threatening risks in the form of seizures.

The woman's blood pressure was on the low side during the three days it was recorded, but was similar to her previous admission when the combination of these two regimes progressed without incident. These readings could therefore have been normal for the woman.

The toxicology report now confirms that the woman did indeed take additional Amitriptyline, as alleged by fellow prisoner. This drug, when taken in combination with both diazepam and Methadone, increases the respiratory depressant effects of these drugs still further. The post mortem concludes that death was as a result of 'mixed drug toxicity'.

It is unlikely that the woman would have had any awareness of the risk of taking Amitriptyline in addition to her prescribed medication, and it would seem from previous prison records that she had taken this drug illicitly on at least one other occasion.

RECOMMENDATIONS

The following recommendations were made in the draft report. The Prison Service's responses are included in a table following each recommendation:

1. The Governor should remind all staff who work in the communications room of the purpose of contingency action plans and the circumstances when these plans should be followed. Where appropriate, the Governor should arrange for staff to be retrained.

Prison Service Response		Target date for completion	Progress
<i>Recommendation accepted</i>	<i>Training for OSGs to be organised by Training development Group.</i>	<i>Complete</i>	<i>Contingency plans are in the process of being reviewed and updated. Anticipated date of completion 30.06.06</i>
	<i>Communications staff to be reminded of purpose of contingency action plans through SPDR process.</i>	<i>30.06.06</i>	
	<i>Contingency checklist to be drafted for Code Red/Blue incidents.</i>	<i>30.06.06</i>	

2. The Governor should review his prison's contingency plan for dealing with deaths in custody with particular regard to:

- a. Allowing first officers on scene to request attendance of the ambulance service if they consider that to be appropriate. This is in accordance with the Department of Health guidance.
- b. Making it clear, in line with PSO 2700, that where rigor mortis has clearly set in it is unnecessary to attempt resuscitation.

Prison Service Response		Target date for completion	Progress
<i>Recommendation accepted</i>	<i>Contingency plans to be reviewed and amended by Security Committee.</i>	<i>30.06.06</i>	
	<i>a. Notice to staff published.</i>	<i>Complete</i>	
	<i>b. Notice to staff published.</i>	<i>Complete</i>	

3. The Governor should review the arrangements for notification to families of a death in custody, following the advice set out in the supplementary guidance to PSO 2710.

Prison Service Response		Target date for completion	Progress
<i>Recommendation accepted</i>	<i>Contingency plans to be reviewed and amended by Security Committee.</i>	<i>30.06.06</i>	

CLINICAL RECOMMENDATIONS

The following recommendations were made in the draft report. The Prison Service's responses are included in a table following each recommendation. All of the recommendations were for consideration by the Governor of Eastwood Park in conjunction with the Primary Care Trust. However, some of the recommendations were also for consideration by Prison Health.

1. Reception Health Screening

1.1. A Full Reception Health Screen should be undertaken when a prisoner returns to custody after a period of release, no matter how brief that has been.

1.2. A full substance misuse history should be recorded, particularly with regard to drug usage within the last two weeks with details of amounts used and routes of administration.

Prison Service Response		Target date for completion	Progress
<i>Recommendation accepted</i>	<i>1.1. Notice for all healthcare staff placed in reception.</i>	<i>Immediate Complete</i>	<i>Full reception screen is now completed on return.</i>
	<i>1.2. As above for full substance misuse history.</i>	<i>Immediate Complete</i>	<i>Now being completed.</i>

2. Benzodiazepine Prescribing

2.1. Previous benzodiazepine prescriptions must be confirmed with the community prescriber as soon as possible after arrival in prison.

2.2. Where the admission urine test for benzodiazepines is negative, withdrawal monitoring should be undertaken to support the decision with regard to the level of diazepam prescribed.

2.3. Where dependency on benzodiazepines is in doubt, low dose prescribing accompanied by withdrawal monitoring should be undertaken. Alternatively, prescribing can be withheld pending the emergence of withdrawal symptoms. In the latter case, withdrawal monitoring needs to be undertaken over an extended period, as withdrawal symptoms can emerge some weeks after the use of these drugs was discontinued.

Prison Service Response		Target date for completion	Progress
<i>Recommendation partially accepted (locally)</i>	<i>2.1. We already do this to the best of our ability – even with the constraints of resources and the availability of information within some practices.</i>	<i>Immediate Complete</i>	<i>This is now validated via GP. Protocol in place to ensure compliance.</i>
	<i>2.2. Protocol extending across Primary Care, GPs and substance misuse must be drawn up.</i>	<i>30.06.06</i>	
	<i>2.3. As above.</i>	<i>Complete</i>	

3. Previous medical records should be married up with the current admission and examined as part of the early assessment as an additional check for consistency of histories regarding drug usage or to note changes over time.

Prison Service Response		Target date for completion	Progress
<i>Recommendation accepted</i>	<i>This will become part of the administration role as it is developed and be incorporated into their job specification.</i>	<i>Complete</i>	
	<i>Substance misuse nurses to be aware of this recommendation.</i>	<i>Complete</i>	

4. Monitoring Drug Withdrawal

4.1. When drug withdrawal is noted, details of the symptoms should be described.

4.2. Formal withdrawal monitoring should be undertaken for at least the first 72 hours as per PSO 3550 (Clinical Services for Substance Misusers).

Prison Service Response		Target date for completion	Progress
<i>Recommendation accepted</i>	<i>4.1. Staff will record details of withdrawal symptoms.</i>	<i>Immediate Complete</i>	
	<i>Substance Misuse Manager has devised a scoring chart and is planning to implement this as an assessment tool.</i>	<i>Complete</i>	
	<i>4.2. To be introduced and implemented.</i>	<i>Immediate Complete</i>	

5. Drug Urine Testing

5.1. All drug urine test results should be listed in patients' records, including negative results. The seven substances which should be tested for on admission are: opiates (Morphine), Methadone, benzodiazepines, amphetamines, cocaine, cannabis and buprenorphine (Subutex).

5.2. Consideration should be given to using semi-quantitative urine testing for the drugs against which a prescription is likely to be made: opiates, Methadone, buprenorphine and benzodiazepines.

Prison Service Response		Target date for completion	Progress
<i>Recommendation partially accepted</i>	<i>5.1. Cannabis not currently tested as results would not affect treatment or outcome. Subutex is tested on separate test – but only if the history is reported. The remaining 5 are always tested in reception and recorded in IMR.</i>	<i>Complete</i>	
	<i>5.2. Advised that funding will be available through the Integrated Drug Treatment System (IDTS).</i>	<i>30.10.06</i>	<i>Ongoing</i>

	<i>Recommendation agreed subject to funding.</i>		
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6. When there is any concurrent infection during detoxification, twice daily observations should be undertaken of temperature, pulse and respiration.

Prison Service Response		Target date for completion	Progress
<i>Recommendation accepted</i>	<i>Current practice is to test temperature, pulse and respirations once a day if an infection is present. Will change procedure to twice daily observations of temperature, pulse, respiration and blood pressure.</i>	<i>Complete</i>	

7. If it is not already the case, a defibrillator must be located in the detoxification unit.

Prison Service Response		Target date for completion	Progress
<i>Recommendation partially accepted</i>	<i>There are currently 2 in operation within the establishment. A bid will be submitted as part of the IDTS funding allocation.</i>	<i>Complete</i>	

8. Consideration should be given to the levels and quality of observation undertaken at night time. Consideration should also be given to whether staff need educating with regard to the importance of noting changes to breathing that occur over night.

Prison Service Response		Target date for completion	Progress
<i>Recommendation accepted</i>	<i>Protocol in place..</i>	<i>Immediate Complete</i>	<i>Protocol will be reviewed by substance misuse manager</i>

9. In Possession Medication

9.1. With the exception of asthma inhalers and topical creams, assessment for in-possession medication should not take place until the intensive phase of detoxification is complete.

9.2. When progressing to the post detoxification phase, some limited in-possession medication may be considered according to individual risk assessment. Evidence of recent substance misuse will always be a risk factor to consider.

Prison Service Response		Target date for completion	Progress
<i>Recommendation accepted</i>	<i>9.1. In possession medication, with the exception of specific inhalers and topical lotions, will only be allowed in possession on the detox unit. In possession meds will be assessed for patients when they are transferring off</i>	<i>Complete</i>	

	<i>the unit only. .</i>		
	<i>As above.</i>	<i>Complete</i>	

10. Both the intensive phase and post detoxification units should have additional bedding available for the women in those units.

<i>Prison Service Response</i>		<i>Target date for completion</i>	<i>Progress</i>
<i>Recommendation accepted</i>	<i>Additional bedding to be made available on request.</i>	<i>30.06.06</i>	

COMMENTS ON DRAFT REPORT FROM THE WOMAN'S PARENTS

Following issue of the draft report, the woman's parent's asked to meet the lead investigator and my Family Liaison Officer. At the meeting, the womans parents raised the following matters:

- They remarked upon the system at Eastwood Park where officers share the counting of prisoners but only one officer signs to confirm that the count has taken place. This meant that neither of the staff who counted the prisoners on the night of 3 June could remember who had counted the prisoners where their daughter was roomed.
- They were concerned about how the senior officer came to believe, mistakenly, that their daughter had a ligature round her neck. They were also concerned about the decision not to try to resuscitate her.
- They were concerned about illicit drugs in Eastwood Park:
 - o that it seems so easy for visitors to bring drugs into the prison.
 - o that no action was taken against their daughter when she previously received drugs from her boyfriend.
 - o that the prison had not tried to trace the woman who had given their daughter the amitryptiline.
- They were concerned about the level of training and specialist experience of the nursing staff responsible for initial health assessments. Particularly when dealing with prisoners requiring drug detoxification.
- They remarked upon the amount of time it had taken for the ambulance to arrive at Eastwood Park.
- They remained concerned and upset about the way in which the news of their daughter's death had been conveyed to the family and to the media.