INVESTIGATION INTO THE CIRCUMSTANCES

OF A WOMAN

AT HMP EASTWOOD PARK

PRISONS AND PROBATION OMBUDSMAN
FOR ENGLAND AND WALES
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This woman died on in June 2004. She had been recalled to prison on 3 June for breach of home detention curfew and was housed on the detoxification wing at HM Prison Eastwood Park where she was receiving medication. The post mortem report indicates that the cause of death was a pulmonary thromboembolism.

We extend our condolences to this woman's family.

Under my terms of reference from the Home Secretary, I am required to investigate all deaths of prisoners no matter what the cause, to establish what happened, and to see whether there are any lessons to be drawn. The investigation looked carefully at the detoxification care this woman received.

The Prison Health Development Manager for the South West, has conducted the investigation on my behalf working in collaboration with one of my Assistant Ombudsmen. Clinical advice has been provided by two highly experience doctors of the South Gloucester Primary Care Trust and a Consultant Psychiatrist in Substance Misuse.

I am grateful to all those who have contributed to the investigation.

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

STEPHEN SHAW CBE
PRISONS AND PROBATION OMBUDSMAN

CONTENTS

SUMMARY

This woman was recalled to prison from Home Detention Curfew. At the time she was taking various prescribed medication including Dihydrocodeine. At Eastwood Park, she was placed on a methadone detoxification regime and other medication.

She was admitted to prison on a Thursday. On Friday, the woman said she felt light-headed and had fallen in her cell. On Sunday, she exhibited symptoms that can indicate opiate overdose. The woman said it was an adverse reaction to methadone that she had experienced before. She was observed by nursing staff, and her condition improved. On Monday morning, the woman was found collapsed in bed in her cell. Staff attempted resuscitation but she died in hospital later that morning.

The post mortem report indicates pulmonary thromboembolism as cause of death. The pathologist's report indicates that the detoxification treatment had no connection with her death. The subsequent coroner's inquest held on 24th February 2005, returned a verdict of:
'Natural causes as a result of pulmonary thromboembolism'.

The Ombudsman concludes the report with five recommendations. In addition, specialist clinical advisers have examined the circumstances and made recommendations about healthcare, medical record-keeping and the care and treatment of women withdrawing from substance misuse.

HMP EASTWOOD PARK

Eastwood Park is a women's local prison which holds remand and short term sentenced prisoners. It has an operational capacity of 346.

The accommodation is a mix of refurbished 1960s accommodation and some new buildings.

B wing is a small, refurbished self-contained area which is part of the original older construction. It has 43 spaces for women undergoing detoxification from substance misuse, mainly in double cells. It was opened in the spring of 2004.

Over the last two years the population pressures have meant Eastwood Park has become almost entirely a remand prison and turnover of prisoner population has increased dramatically. The prison serves courts throughout the whole of the southwest, the south Midlands and as far as the edge of the London catchment area.

THE SEQUENCE OF EVENTS

This woman was arrested at Congresbury on Wednesday 2 June at 12:30 and taken to Bridgwater Police Custody Unit .

In police custody, she was seen by the police surgeon. At 20:00 she was given Zyprexa (Olanzepine) 10mg, Dihydrocodeine 30mg and Diazepam 10 mg. At 23:00 she was given Diazepam 20 mg and Temazepam 20mg (a short-acting benzodiazepene with a sedative effect). Next morning at 08:56, the police gave her Cipralex (an SSRI anti-depressant) 5mg, Dihydrocodeine 30mg and Diazepam 10mg.

The woman was then taken to HMP Eastwood Park, where she arrived at 10:20.

One of the senior nurses was called by reception to say the woman had arrived and someone was needed to go through the healthcare admission screening with her. As there was no one else available, the senior nurse volunteered to go and see her rather than her having to wait perhaps several hours in reception, as they usually received prisoners direct from the courts in the afternoon. He completed the first part of the reception screening form and made notes in the continuous medical record sheet.

The notes are full and informative, including contact details for the woman's GP and a list of her medication with dosages. The woman told the nurse she was drinking one bottle of vodka a day but said she was not taking illicit drugs. Her urine tested positive for benzodiazepine and opiates which was not inconsistent with her prescribed medications. On the screening form the nurse has noted concerns about mental health and alcohol withdrawal.

From reception the woman was located on B wing, the detox unit. That afternoon, she saw the Medical Officer. He examined her on B wing. In addition, one of the nursing staff gave him a bag of medication that the woman had brought with her. The woman gave a history of mental illness, drinking alcohol in excess amount and receiving Dihydrocodeine 30mg four times a day from her doctor for opiate abuse. The medical officer said that when he explained that it was not the current policy to prescribe Dihydrocodeine but to use methadone, the woman told him that she had been smoking heroin and had taken methadone in the past so preferred that as a detox. She also gave a history of Diazepam 60mg a day and Temazepam 20 mg at night from her doctor; and in addition Olanzepine 15 mg once a day and Cipralex 5mg once a day for psychiatric problems.

The Medical Officer said he decided to place the woman on the standard two-week methadone detoxification programme. In accordance with the doctor's prescription, the woman received 10mg in the afternoon of Thursday 3 October; on Friday she received 10 mg in the morning and 15 mg in the afternoon; and on Saturday 15 mg in the morning and 15 mg in the afternoon. On Sunday she received a single dose of 30 mg in the morning.

The other medications that she received were Diazepam 20mg in the afternoon of her admission to prison, then subsequently 20 mg in the morning and again in the

afternoon, Olanzepine 15mg once a day in the afternoon and Cipralex 5 mg once a day in the morning. All these medications were administered under supervision of nursing staff. She was also prescribed two inhalers for asthma, Beclomethazone and Salbutamol, which were given to her to keep in her cell.

The Medical Officer made the decision not to use a front-line alcohol detoxification because he considered the relatively large dose of Diazepam to be sufficient to deal with any withdrawals. The Medical Officer expressed some concern that he felt the protocol to use only methadone as the withdrawal medication from opiates had become uniform in women's prisons. He said that methadone was generally a superior treatment to Dihydrocodeine but there should be some facility to use Dihydrocodeine if the clinician judged it more appropriate for a particular individual. Dihydrocodeine is not licensed for detoxification but can be used for symptomatic relief if a clinician considers it appropriate.

The next entry in the continuous medical record is dated 4 October (Friday). No time is given. A Healthcare Assistant has recorded that the woman said she fell in her cell and was complaining of feeling light headed. Her blood pressure was taken and registered 154/98 (slightly elevated) and pulse was 76. The note says that she was to be observed for any further attacks. It is not known how this was communicated to other staff. The Healthcare Assistant was a member of agency staff and has not been interviewed. There is no record of any further observations following the incident.

There are no records of any further incidents on Friday or Saturday but it is recorded that the woman collected her medication as prescribed morning and afternoon.

There are two entries in the medical record for Sunday afternoon 6 June, made by an agency RMN. She states that at 14:45 the woman was very drowsy, her speech slurred, unable to sit up, dribbling, and with pinpoint pupils. Initially she was unable to understand what the woman was saying. Her blood pressure was 133/76 and her pulse 116. The woman denied taking any drugs in prison other than those prescribed for her. The note says the woman then told the RMN that methadone always had that effect on her but she had not liked to say anything when it was prescribed for her. The RMN recorded that the woman was not to have any further does of methadone, she must be closely observed and must be seen by the medical officer next morning.

At 16:20 the RMN tested the woman's urine which was positive for benzodiazepine and methadone, both of which were prescribed. The RMN noted that the woman was looking and feeling better than earlier.

The protocol for the standard detoxification regime at Eastwood Park contains instructions and guidance to the clinicians administering the treatment. The protocol states that the nursing staff dispensing methadone must withhold the treatment if the patient shows signs of intoxication, such as drowsiness, confusion, slurred speech and small pupils. The protocol also contains guidance on the management of opiate overdose. It states that signs of opiate overdose are drowsiness, collapse, slow shallow breathing leading to respiratory arrest and pinpoint pupils. Action to be taken in the event of overdose is to call for an emergency ambulance, start basic life

support and administer Naxolone (an opiate blocker) repeatedly until the ambulance arrives.

The RMN was asked whether she had considered giving the woman Naloxone in view of the symptoms she was exhibiting. The RMN said that she made an assessment of the woman's condition. She also consulted a fellow-nurse and made the decision that the woman's condition warranted close monitoring and did not require the full range of actions described in the overdose protocol being delivered at that time. The RMN stated that the woman was kept under close observation throughout the afternoon and evening and that she handed over the information to the night staff. Those observations are not recorded.

Throughout the weekend the woman's cellmate was being closely monitored because she was thought to be at risk of self-harm. Observations were being made three times an hour and are recorded in the cellmate's file. This would have meant looking in to the cell where both the woman and her cellmate were located throughout the periods when prisoners were locked in their cells. An entry for 06:40 on 7 June notes that the cellmate was helping the woman to go to the toilet.

On Sunday 6 June it appears that the woman started to write a letter and made an entry in her diary about how she was feeling. The note in her diary says she had "overdone it on their detox" and was feeling ill. She expected to be "put on codeine now". In the letter she says:

"Because of the codeine that was in my system they put me on 30 mg meth. a day. Today I think they'll stop it. My legs are swelling up and I'm not that coherent. It's only 2 days from the day you spend on this wing. My legs are really, really swollen. I told them I wasn't on it. I feel ill and it's all down to that."

MONDAY MORNING 7 JUNE 2004

On Monday morning at about 08:15 an officer entered the woman's cell, B1-5, to ask both prisoners if they wanted exercise. The cellmate left the cell and, as she did so, asked the officer to keep an eye on the woman as she had been unwell in the night. The officer recalled in her statement that she entered the cell and asked the woman once more if she wanted exercise. The woman opened her eyes and shook her head. The officer went back to the cell about 30 minutes later and shook the woman and asked her if she was OK. She 'grunted' in response. Further to this the officer went to the cell at 09:30 to return the cellmate from exercise and at that time observed the woman breathing.

Another officer entered cell B1-5 at about 09:50 and was concerned with how the woman was lying and breathing. He records that he could not get a response by talking to her or shaking her so he asked an officer to send a nurse to the cell.

The unit manager and senior nurse, was present on the wing and attended within seconds. She found the woman to have no pulse and not to be breathing. She asked an officer to call a Code Blue (emergency call) over the radio to summon urgent assistance. When this was done she asked the officer to call for the Senior Nurse to assist. The senior nurse was also on the unit at the time. Cardio-pulmonary resuscitation was carried out using emergency equipment (an ambu-bag for artificial respiration) brought from the unit office. Resuscitation continued and another nurse arrived within minutes from the outpatient area, some 200-300 yards away, with the automatic defibrillator. She applied the defibrillator pads, did a full check of vital signs and found a pulse but the woman was still not breathing. She recommenced artificial respiration following the defibrillator's guidance. After approximately nine minutes the woman was breathing. She was placed in the recovery position still on the bed and the nurses continued to monitor her condition by close continual observation and with the aid of the defibrillator. Eight to twelve minutes later, it was observed that the woman was no longer breathing and had no pulse. She was placed on the floor and full CPR was recommenced. At no time did the defibrillator detect a cardiac rhythm that was amenable to electric shock. CPR continued until the paramedics arrived and took charge. The ambulance arrived at 10:30, having been delayed by a major accident which partially closed the M5 motorway. They left the prison at 10:55. The woman was taken to a nearby hospital. She was pronounced dead at 11:28.

I understand that a doctor was in the prison during these events and would have been aware of the emergency but was not called to assist.

RECOMMENDATIONS OF THE CLINICAL ADVISERS

In conducting this investigation I have had the benefit of clinical advice from three experts.

Two examined the woman's care from the point of view of primary care. The consultant psychiatrist in substance abuse was asked to advise in particular about the detoxification treatment.

They reports produced contain much valuable expertise and I commend them to the Prison Service and all those who have the care of prisoners suffering the effects of substance abuse.

I set out below the principal conclusions and recommendations from the clinical reviews.

Primary Care

CR1 All staff involved in trying to resuscitate the woman should be commended. They had all had training in basic cardio-pulmonary resuscitation, which should be regularly updated. Defibrillator training should be kept current for healthcare staff.

CR2 Observation of the woman should have been carried on in to the evening of 6 June, with a hand over at change of staff time. Depending on the results of these observations consideration should have been given to carrying them through the night. The afternoon dose of diazepam should have been withheld given the history of marked drowsiness earlier in the afternoon.

CR3 The medical officer should write full notes. From the records there was no indication for prescribing methadone.

CR4 Ambulance access must be looked into. Pathways of getting stretchers from cells to the ambulance should be as unobstructed as possible.

CR5 Critical Event Analysis should be carried out following events such as this, in order to learn from the incident, commend good practice and as a form of support for those involved.

The two doctors conclude their report by noting that the post mortem result reports death by natural causes, multiple pulmonary emboli. There was no sign of a deep vein thrombosis and so there was nothing that could have been done to avoid this.

Consultant Psychiatrist

CR6 It may be that difficulties in staffing contributed to a lack of observations and further assessment and treatment. If vital signs are found to be abnormal, they should be monitored until they return to normal.

CR7 Records of observations of patients who are clinically of concern should be kept. It is likely that the woman was observed considerably more than her records imply. Observations through the door or viewing port are unlikely to be sufficient in cases of clinical concern, meaning that the cell door will need to be opened to make a proper examination and ensure proactive management.

CR8 Symptoms of drug overdose should activate an agreed local procedure, or mean that a doctor should be called. This would include withholding of non-essential and sedative medications and monitoring of respiratory rate and conscious level as well as consideration of appropriate treatment.

CR9 Medication doses reported by a prisoner should be confirmed with the GP where such medications are abusable and there are inconsistencies in the dose specified.

CR10 A detox regime should not automatically be given to patients purely because they have a past history of misuse of certain drugs and test positive for them, as seems to have happened in this case where methadone was probably completely clinically unnecessary. A good standard of clinical care requires good assessment and individualised care.

CR11 Clinical evidence of physical dependence on opiates or benzodiazepines should be elicited prior to starting a detox regime for these drugs. In situations where uncertainty exists over the presence of a physical dependence, the prisoner should be observed, and treatment commenced if objective withdrawal symptoms develop, While such observations are difficult to achieve in a prison environment, they are essential in order to provide a reasonable standard of clinical care.

CR12 In this particular case the urine screening test which was found to be opiate positive, did not distinguish between the presence of morphine (which could be related to heroin) and the presence of Dihydrocodeine. It may be a training issue that immunological screening tests do not detect morphine only and that Dihydrocodeine comes up positive on opiate screens, even though it is only metabolised to morphine, A confirmatory urine screen would have distinguished Dihydrocodeine from morphine, but such tests often require a wait for the result which may mean they are not particularly suited to a prison context.

Relying on the pathologist's report, the consultant psychiatrist concludes, in summary, that it appears that, although the woman did not receive the quality of treatment that would have been expected in the community, her death does not appear to be directly related to these factors and it is unlikely that her death would have been prevented if she had received such treatment.

CONCLUSIONS AND RECOMMENDATIONS

The purpose of my investigation is to establish the circumstances surrounding the death, in part to see whether there are any lessons that the Prison Service can draw about the care and treatment of prisoners. The investigation therefore examined in detail the care extended to this woman in the few days she spent at Eastwood Park immediately before her death. She had a history of drug and alcohol misuse and was taking a variety of prescribed medication before her recall to prison. She was located in the detoxification unit and received prescribed medication including methadone.

The post mortem conducted for the Coroner has found that the cause of death was a pulmonary thromboembolism. The pathologist has indicated that she sees no connection between her detoxification regime in prison and her sudden death.

When my investigation began I did not have the benefit of the pathologist's findings. The investigators necessarily examined all the circumstances with an open mind. The investigation has identified some areas of good practice and some areas of concern which I consider should be shared with the Prison Service and those responsible for prisoners' health even though not all are directly related to this death.

Accordingly, I make the following recommendations:

R1 **The efforts that the staff made to resuscitate this woman are to be wholly commended. They demonstrated good skills and the use of the defibrillator was good practice. The staff showed both persistence and a high level of care in their attempts at resuscitation. The Governor should draw these comments to the attention of the staff concerned.**

R2 **The outcome would not have been altered in this instance, but the Governor should ensure that response protocols in the prison include the attendance of a doctor at serious incidents such as this if a doctor is present in the prison.**

R3 **On admission to prison, she was apparently stabilised on Dihydrocodeine prescribed by her doctor. I recommend that prisons should be advised that the detoxification regime should not automatically be given to patients purely because they have a past history of the misuse of certain drugs or test positive for them. A good standard of clinical care requires individualised assessment and care.**

R4 **There are clear gaps in the patient records which fail to demonstrate the care properly afforded to the woman. Records must be maintained to the standards for professional practice laid down by the General Medical Council and the Nursing and Midwifery Council. The records must provide clear evidence of the care and treatment planned, the decisions made, the care and treatment delivered, and what information has been communicated to others. I recommend that my comments be drawn to the attention of all medical staff at Eastwood Park.**

R5 The Governor should arrange a review of the protocols for treatment of suspected opiate overdose in view of the comments made by the clinical advisers.