

**Investigation into the circumstances surrounding the
death of a woman
at HMP & YOI Holloway in August 2010**

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

October 2011

This is the report of an investigation into the circumstances surrounding the death of a woman. She was found dead at about 7.40am in August 2010 in her cell on the substance misuse unit at HMP Holloway. She was 37 years old. It was not her first time at the prison and she had only arrived 14 hours earlier. Post mortem and toxicology reports indicate that her death was due to morphine toxicity.

She struggled with substance and alcohol misuse for many years. She also had a number of other serious physical illnesses. I would like to offer my sincere condolences to her family and friends.

The investigation was led by one of my investigators. In addition, a review into her medical care was undertaken by a clinical reviewer, a Nurse Consultant (substance use) for the local Primary Care Trust (PCT). I am grateful to him for his assistance. I also thank the Offender Health Clinical Substance Misuse Lead for providing advice in the matter of treating substance misuse in prisons.

I am grateful to the Developing Prison Service Manager (DPSM) who provided a high standard of prison liaison, and the staff and prisoners for their co-operation with my investigation.

The investigator contacted the police investigating officer who provided a copy of the woman's police custody record for the time she spent in police custody before she came to Holloway. I would like to extend my thanks to the Metropolitan Police for their assistance.

She had been in the custody of Serco Escort Contractors at the Magistrates' Court the day before her death, before arriving at Holloway. Serco conducted an internal investigation into her detention at court and provided relevant information to the investigator.

As is often the case in investigations following a death from drug misuse, I rely heavily on the findings of the clinical review. I make six recommendations as a result of this investigation. They concern the use of the Person Escort Record, training nursing staff about the needs of detoxifying prisoners, staff recording their observations of prisoners going through the detoxification phases, referral to outside hospital for prisoners presenting with acute physically unwell symptoms, the accuracy of medical records and the carrying out of cardio pulmonary resuscitation. The prison service has accepted five of the six recommendations and their comments on these can be found at page 25 in this report.

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

Thea Walton
Acting Prisons and Probation Ombudsman

October 2011

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SUMMARY

1. The woman was 37 years old when she died. She had been arrested on Friday 27 August 2010 and detained at a police station. During the night she was sick on the cell floor. The following morning, Saturday 28 August 2010, she was taken by Serco escort contractors to the Magistrates' Court, arriving at around 8.30am. She had vomited on the escort vehicle and was sick again while waiting to appear in court.
2. She appeared in front of the magistrates, charged with shoplifting and failure to attend court (on the same charge) on an earlier date. She was sentenced to seven days in custody for failing to attend court and was to return at a later date for the court to consider the shoplifting charge. It was not her first time at Holloway, as she had spent two previous periods in custody there.
3. At about 4.20pm, she arrived at the prison. On arrival, Serco staff reported to prison reception staff that she was unwell. Serco staff had recorded on the Person Escort Record (PER) that she possibly had asthma, kidney failure, hepatitis A, B, C, and HIV, and was also an alcoholic.
4. Whilst in the reception area, she was seen lying on the floor, having vomited. She was quickly assessed by nursing staff. A urine sample was taken and she tested positive for cannabis, morphine, cocaine and benzodiazepines. She was quickly taken through reception to the First Night Centre, where she continued to appear weak and sick. She was assessed by the doctor on duty and prescribed medication for her sickness and withdrawal symptoms to prevent her from having seizures.
5. She was then taken to Ivor ward (the substance misuse wing), arriving at approximately 6.30pm, when she vomited again. She was in a dormitory with three other prisoners where she settled for the evening. Healthcare staff tried to administer anti-sickness medication twice during the evening, but she refused to take it.
6. Staff last spoke to her just before 10.00pm, when she agreed to take medication for her alcohol dependency. No other concerns were raised. The following morning, during the roll check at approximately 7.25am, she was found to be unconscious. The alarm was raised immediately and cardio pulmonary resuscitation (CPR) was carried out and an ambulance called. Paramedics arrived but they were unable to resuscitate her and confirmed her death at 7.50am.
7. I make six recommendations as a result of this investigation. They concern the use of the Person Escort Record, training nursing staff about the needs of detoxifying prisoners, staff recording their observations of prisoners going through the detoxification phases, referral to outside hospital for prisoners presenting with acute physically unwell symptoms, the accuracy of medical records and the carrying out of cardio pulmonary resuscitation. The prison service has accepted five of the six recommendations and their comments on these can be found at page 25 in this report.

THE INVESTIGATION PROCESS

8. The investigation into the woman's death was opened by one of my investigators on 3 September 2010, when he visited HMP Holloway. He met the Acting Governor, Acting Deputy Governor and some of their staff. Notices of the investigation and terms of reference had already been sent to the prison to invite anyone with any information to contact my investigators. He later returned to the prison to interview staff. A prisoner also came forward to be interviewed.
9. He also met representatives of the Prison Officers' Association and the Head of Healthcare. He visited the reception and the substance misuse unit (Ivor ward), where the woman lived during her short time in custody. Following completion of staff interviews, he fed back his initial findings to the Acting Deputy Governor.
10. A clinical review was commissioned from the local Primary Care Trust (PCT) to assess the woman's medical care. As well as conducting interviews with the investigator, the clinical reviewer visited the prison to speak to healthcare staff and observe the care they give to prisoners.
11. In the course of this investigation, it was discovered that the woman had received medical care whilst she was in police custody. As there is no mention of this on her PER form which accompanied her when she was handed over to the Serco Escort Contractors, I have informed the Independent Police Complaints Commission.
12. One of my Family Liaison Officers (FLOs) contacted the woman's brother, who was named as her next of kin and informed him of my investigation. At the time of the investigation, her family had not raised any questions or concerns about the circumstances leading to her death.

HMP HOLLOWAY

13. Holloway is the second largest female prison in Europe and occupies a site in urban North London. The accommodation is split between single rooms and multi-occupancy dormitories.

Her Majesty's Chief Inspector of Prisons (HMCIP)

14. The most recent inspection by Her Majesty's Deputy Chief Inspector of Prisons was an unannounced full inspection in April 2010. Published in July 2010, his comments included:

“Clinical management for substance users had improved, with more flexible maintenance prescribing, but opiate-dependent women received no first night treatment unless they were pregnant. The specialist clinical team and staff on the stabilisation unit provided safe care, but the clinical team was heavily reliant on agency staff. It was good to see that the proportion of women arriving at Holloway who required admission to the stabilisation unit had dropped considerably by 30% in the year. The positive mandatory drug test rate was low at just over 3% and there was an appropriate supply reduction strategy.”

“The needs of the women are many and varied, with drug and mental health issues prominent.”

“Worryingly, given the vulnerability of the population, first night procedures were not sufficiently robust and there was no first night treatment for most opiate-dependent women.”

Ivor ward substance misuse unit (H1 and D1 landings)

15. The Ivor ward (H1 and D1) was opened in August 2006 and is the prison's dedicated substance misuse unit. H1 is the detoxification landing and it holds up to 40 women. There are 19 more beds on D1 landing, which is the post-detoxification landing, and the healthcare and discipline staff cover both landings. During the night period, a nurse and healthcare assistant are on duty.
16. There are some single cells but most women share dormitories which can sleep four. Women stay on the unit for varying lengths of time depending on their treatment and move to the main prison after assessment. All cells have a cell bell which enables prisoners to alert staff should they need assistance.
17. Clinical records are stored on an electronic record system called EMIS. The New Patient Health Check undertaken by a nurse and the reception doctor's assessment are set up on EMIS in template form. The continuous clinical record, where daily events and interventions are recorded, is also on EMIS. Other records, such as the withdrawal monitoring chart and individual care plans, are paper based. EMIS is only accessible to clinical staff. Occurrences that clinical and discipline staff all need to be aware of should be recorded in the wing observation book which is kept in the main office on H1.

Cell Sharing Risk Assessment (CSRA)

18. In order to make sure that unsuitable prisoners do not share cells (for example to prevent the location of a known racist prisoner with someone of the targeted group or a prisoner with disturbed behaviour or mental illness from cell sharing inappropriately), a cell sharing risk assessment is completed by reception staff when a prisoner first arrives.

Person Escort Record (PER)

19. The PER form accompanies each prisoner on all their journeys between police, courts and prison, as well as any other journeys. It is compiled by the escort staff and gives a chronological record of the journey, for example when meals were served or the time a journey started. It includes a section which records whether a prisoner poses any risks to themselves or others. The PER is the main way to ensure that information about the risks to prisoners taken out of the prison is always available to those responsible for their custody.

Reception

20. When a prisoner arrives at a prison, their records are handed over by the escorting contractor. The prisoner is booked in by staff at the front desk, their details are checked against the documentation and the relevant files are opened. Prisoners wait in a waiting room and see staff individually. They are searched, their property is checked and they are given clothes and information about prison. Prisoners are then escorted to the First Night Centre where they will receive a healthscreen. Dependant on a prisoner's time of arrival, they are also allowed to make a telephone call.

Emergency response

21. Emergency codes are used to summon staff to deal with a particular situation. Holloway uses two medical emergency codes which are called over the radio: Code Blue for life threatening emergencies and Code Black when there are no signs of life
22. The night nurse and healthcare assistant on Ivor ward carry a cell key in a sealed pouch but, except in a medical emergency, they are required to call discipline staff if they need to open a cell door at night. The night orderly officer is in charge of the prison at night and there are four response officers who are designated to respond to any calls.

Roll check

23. The roll check is the physical count of the number of prisoners on each wing within a prison. Roll checks occur on a number of specified occasions during the day and night, and staff sign that the roll is correct.

Serco Escort Contractors

24. Serco are contracted to provide the safe, timely and secure transportation of prisoners between Police stations, Courts and HM Prisons. Serco staff also manage the court custody suites and accompany prisoners into the courtroom.

Previous deaths at Holloway

25. This is the third natural cause death at Holloway since 2004 when my office became responsible for investigating all deaths in prison custody. Neither of the other deaths were in similar circumstances to the woman's death.

KEY EVENTS

Friday 28 August, prior to the woman being taken to HMP Holloway

26. On 20 June 2010, the woman allegedly stole a pair of sunglasses. She was arrested and bailed to appear at court on a later date. Having failed to attend court, she was arrested again on 27 August and held in police custody at a police station.
27. She arrived in police custody at about 10.30pm. A risk assessment concluded that she was to be assessed by a doctor or nurse because she had several medical issues. Of these, it was noted that she had not taken her medication since June and she was an alcoholic. She was to be checked every 30 minutes.
28. At 11.36pm, police custody records note that she was “being sick on floor”. She was examined by a nurse who wrote on the medical form that she was “Awoken from sleep, say’s she’s ‘rattling’ [the term is commonly used to refer to withdrawal from drugs] - no clinical sign of withdrawal. Polymedical issues but non-compliant with treatment.” Staff continued to check on her every 30 minutes.
29. The following morning, 28 August, at 6.50am, she was seen again by the same nurse who had examined her the previous night. She was given Diazepam (used to treat anxiety disorders, agitation, tremors, delirium, seizures and hallucinations resulting from alcohol withdrawal).
30. Later that morning she was collected from the police station by Serco Escort Contractors some time between 7.32am and 8.17am. The police provided Serco with the Person Escort Record (PER) which had been prepared overnight. The PER indicated that she had the following risks:
 - Asthma
 - Kidney failure
 - Alcoholism
 - Hepatitis A, B, C
 - HIV
31. At 8.20am, she arrived at Magistrates’ Court. Having been taken off the Serco escorting vehicle, one of the escort staff noticed that she appeared unwell and was carrying a sick bag. She was taken to a holding cell. She lay down on the cell bench but, shortly afterwards staff noticed that she had vomited on the floor. Escort staff increased their checks on her, who did not speak to them but nodded when she was spoken to. She went to sleep when she stopped vomiting. Staff provided her with water, but she refused to eat later that day.
32. The court sentenced her to seven days imprisonment for failing to attend court. She was to return to court at a later date for consideration of the shoplifting charge. She was taken from the holding cell to the escorting vehicle to be

taken to Holloway. The vehicle left the court at 3.55pm. She was checked at 4.00pm and 4.10pm whilst on route to Holloway and no concerns were raised.

Saturday 28 August, 4.18pm, the woman's arrival at Holloway

33. The escorting vehicle arrived at Holloway at 4.18pm. When checked, she still seemed to be unwell and she told the escorting officer that she was "going to die today".
34. The officer took the paperwork to the prison reception. She spoke to the reception officer, Senior Officer (SO) A. It was agreed that she would be taken off the vehicle first as she was clearly unwell. She would be seen immediately by prison reception staff. When the staff returned to the vehicle to collect her, she was slumped on the floor. She was taken off the vehicle and into reception by the two escort staff.
35. The SO told the investigator that she could not remember exactly how the Serco officer had described her, but they had indicated that she was "poorly". She spoke with her and recognised her from a previous period in custody at Holloway. She confirmed her name and date of birth but looked very pale and weak. She was taken to a holding cell and immediately made her way to the bathroom within the cell. The SO said she heard what sounded like vomiting noises from the cell.
36. Officer A was on duty in the reception area. The SO had told her that the woman was very unwell. Having seen her before, the officer believed that she had not seen her look so unwell in the past. Reception staff wanted to help her through the reception process as quickly as possible so that she could be seen by the doctor.
37. Having collected the relevant paperwork, the SO returned to the holding cell and found her collapsed on the floor. She immediately alerted Nurse A, who was on duty in the reception area. She responded to the nurse when she spoke to her and got off the floor. The SO said that it was obvious that she was "quite sick" and she completed the reception procedures as quickly as possible so that she could be taken to the wing.
38. The officer began by searching her and then booking her property at the property desk. She was not responsive and could not sign any of the documentation because of her physical state. When she sat down, she sank again to the floor. She was moved to the holding room and all the necessary checks, where possible, were carried out there so that she did not have to move again. The officer said that she became a little more responsive and was able to stand up so that her photograph could be taken.
39. Officer B completed the cell sharing risk assessment (CSRA) and recorded her as a "Medium" risk (this indicates "no immediate risk, but situation will need to be reviewed regularly"). He noted that she had drug and alcohol issues as well kidney failure. The nurse conducted a urine sample. From reviewing her

medical records, the clinical reviewer confirmed that she tested positive for morphine and cocaine.

40. The woman hardly spoke to the SO aside from saying that she felt cold and so she was given her coat back. The SO told the investigator that she had never seen a prisoner arrive into custody looking as weak as her. The SO believed that she needed to be seen by the doctor as quickly as possible.
41. She was assessed by Nurse B. He told the investigator that he worked in reception and saw all the new prisoners for an initial health assessment. He did not have any formal training in detoxification.
42. The nurse remembered her from her two previous periods in custody. When he went to collect her, she was on the floor in the holding cell. He called her name, and she responded and rose to her feet. They went next door into the nurse's assessment room. He said that she appeared very ill and he conducted his clinical observations as best as he could. He measured her weight (52kg), height (173cm), blood pressure (115/83 mm Hg), pulse (66 beats per minute) and body mass index (17.37) readings, as quickly as possible so that she could be seen by the doctor and go to a wing.
43. Her clinical observations were considered to be within the normal range. From his previous contact with her, he said she had always been reluctant to talk about her drug use when she was withdrawing. On this occasion, he said that he could not to ask the questions that he would normally ask of a new prisoner, because she was not in a fit state to respond. He said it was "clearly evident that she was withdrawing" from drugs and alcohol and he noted her medical records accordingly.

Saturday 28 August, 5.00pm, the woman's move to the First Night Centre

44. After completing her reception checks, she was taken to D2 unit, the First Night Centre, by the SO. She was able to walk unaided and the SO handed her over to the staff on duty.
45. Officer C told the investigator that she was on duty on the First Night Centre when the woman arrived around 5.00pm. As soon as she arrived, it was obvious that she was not well and she appeared to be suffering from symptoms of withdrawal. A few minutes after arriving, she said she wanted to be sick and so she was directed by the officers towards the toilet. The officers, who were also attending to other prisoners, were told by them shortly afterwards that she was lying on the floor in the toilet.
46. Both officers went to see her. They gave her a sick bowl and helped her walk to the nurse, who arranged for her to see the doctor. Officer C asked her if she wanted to make a telephone call and have something to eat. Despite being a little incoherent, she refused both offers.
47. The woman left the room and walked into the dormitory next door where she immediately lay down on one of the beds. At every opportunity, she wanted to

lie down. Officer D said that she did not want to engage in conversation except to say that she was tired. After about 20 minutes, both officers brought her to the television lounge where she waited to be seen by the doctor. Again, she lay down on the chairs.

48. Officer C said that Holloway receives a high number of prisoners who are withdrawing from drugs. The officer thought that she appeared to one of the worst cases she had seen coming on to the Induction unit. The officer left the prison and went off duty at 5.30pm.
49. At interview with the investigator, Prison Doctor A said that he assessed her shortly after 6.10pm. He hoped to gather information about her medical history, general health, alcohol and drug use. The doctor remembered her from her two previous periods at Holloway. He knew that she depended on alcohol and opiates and, at that time, appeared to withdrawing. This conclusion was supported by the results of the urine sample taken earlier by the nurse and her presentation. She held a sick bowl in her hand which did not surprise the doctor, who recalled that she often felt sick when suffering from withdrawal symptoms.
50. He used a standard healthcare template of questions to elicit information from her. She was coherent when she answered and described her medical condition as the same as it had been when she was last at Holloway. She said that she was currently drinking about one bottle of vodka a day, and last drank alcohol the previous day. She also admitted to using crack cocaine and heroin. She was sweating, restless, held her stomach and bent down whilst the doctor assessed her. She continually told the doctor that her condition was the same and she wanted to be taken to Ivor ward.
51. After finishing his assessment, the doctor concluded that she was alcohol and opiate dependant and suffering from physical withdrawal symptoms. She was to be referred to the drug misuse service and doctor. He prescribed:
 - 20mls of methadone (for her heroin dependency)
 - an inhaler for her asthma symptoms
 - a domperidone suppository to reduce her nausea and vomiting
 - hyoscine butylbromide (to reduce abdominal pain)
 - chlordiazepoxide (also known as Librium, a treatment for alcohol dependency)
 - Vitamin B.

The policy at Holloway is that methadone treatment for drug withdrawal starts the day after the prisoner comes into prison.

52. The doctor also said that he prescribed carbamazepine to prevent her having seizures. However, having checked her electronic clinical records, neither the investigator nor the clinical reviewer have found any record of the carbamazepine prescription although the information was included in her drugs chart.

53. The doctor was aware of her HIV and Hepatitis C status from her records. He confirmed that the healthcare wing would liaise with her to conduct tests in their HIV clinics and provide further treatment for these conditions.
54. Her medical assessment was completed by approximately 6.30pm. She was escorted downstairs to Ivor ward by Officer E. Officer F was on duty on the ward and she received her and her paperwork from the officer. The paperwork included her risk assessments and her medication chart, which was handed to Nurse C, the substance misuse nurse.
55. Officer F told the investigator that the woman was unsteady on her feet. She said that this was not unusual and the officer had seen prisoners like this before when they arrived on Ivor ward. As she helped her, she collapsed to the floor and started to be sick. A nurse had gone to collect a sick bowl but she vomited before the nurse returned. After she had vomited, she was more responsive and talked to the nurse and the officer. They agreed to take her to a cell so that she could lie down and rest and could be assessed further by the nursing staff.
56. She was helped to her feet. She could walk unaided and received her tobacco pouch and identification card from the officer. She was taken to a four person dormitory (Number 26), where the other three occupants were already there when she arrived. The officer left her belongings and some fresh sheets to make up the bed. She said that she just wanted to lie down and the officer told her to call if she needed anything. The officer returned to the office to complete the woman's paperwork.
57. Prisoner A told the investigator that when the woman arrived in the dormitory, she was holding a sick bowl in her hand. She described her as quite ill and sick. The prisoner assumed that she was withdrawing from heroin because she was on the detoxification wing.
58. Nurse C, the detoxification and mental healthcare nurse, reviewed the medication chart. She noted that the doctor had prescribed an alcohol detoxification programme and she should be given methadone the next day. The anti-sickness medication, domperidone suppository, which is normally given immediately to anyone withdrawing from alcohol, was noted on the medication chart but was not listed on her prescription. The nurse told the investigator that she went to see the doctor and asked him to write a prescription for this medication.
59. The nurse returned to Ivor ward at about 6.55pm. As the prison was now in patrol state and all the prisoners were locked in their cells, the nurse had to ask permission from the Control Room to go into the cell to give the woman her medication. She also had to be accompanied by an officer. Permission was given and, at 7.00pm, Officer F opened the dormitory and went in with the nurse. Another officer, Officer G, remained at the doorway. The nurse told her what the suppository was by saying that it would help calm her vomiting but she refused to take the medication.

60. The nurse said that it was necessary to manage her vomiting and to keep it under control so that any oral medication could later be given, including carbamazepine. Had she been given carbamazepine and then vomited, it would not be possible to administer another dose immediately.
61. Officer F also checked with her to ensure that she understood what the nurse had explained to her. The staff then left and locked the dormitory, she having refused to take the medication.
62. Prisoner A said that all the other prisoners introduced themselves to her shortly afterwards and asked her if she needed anything. The prisoner offered to make up her bed but said that all she wanted to do was to lie down. She asked the prisoner to roll up a cigarette although, when she was given it, she did not smoke it. The prisoner also asked her if she wanted a hot drink, but she declined and covered herself with a blanket.
63. She was checked at 8.00pm by Nurse D, who reported to the nursing staff in the office that she was lying on her bed, talking to the other women in the dormitory. An hour later, at 9.00pm, Nurse C's shift finished and she handed over to the night duty nurse, Nurse E. Nurse C told Nurse E that the woman was a new admission who had vomited earlier and had not taken any medication. Officer F confirmed this before finishing her own shift at 9.15pm.
64. Nurse E told the investigator that, as part of her handover from the day duty nurses, she was told that the woman had vomited in the corridor when she arrived on Ivor ward. She had been offered an antiemetic (domperidone) and ibuprofen (pain killers) but refused saying they made her sick.
65. Just before 10.00pm, Nurse E carried out her medication round. The woman was the last person in her dormitory to collect her medication and she spoke to the nurse at the cell hatch. She took the Librium but again refused ibuprofen and a domperidone suppository, saying that they made her feel sick. The nurse talked with her for a short while because she recognised her from her previous time in custody. She told the nurse that she was okay. The healthcare assistant also went round each of the dormitories giving the women a hot drink and biscuits. She had some biscuits.
66. Whilst she was at the cell hatch, Prisoner A made her bed up for her. When she returned, she covered herself with the blankets. Shortly after this, the prisoner turned the television and lights off in the dormitory.
67. The cell hatch had been left down, meaning that it was fully open, throughout the night in order that the staff could observe the occupants. Nurse E said that staff were concerned about two of the other prisoners in that dormitory. One was being monitored by the suicide prevention procedures and another had been drowsy and had medication problems. As such, the nurse said that she regularly went to the door throughout the night to check all the occupants of the dormitory. No records were kept of the timing of the checks or what the nurse observed. The woman had gone to sleep after taking her medication and appeared to remain so when the nurse checked upon the occupants of the cell.

Sunday 29 August

68. Another prisoner, Prisoner B, was unavailable to be interviewed, as she was released from prison shortly after the woman's death. However, Prisoner A said that this prisoner had told her that the woman had woken up at about 2.00am. This prisoner made her a hot drink and they talked for a while before going back to bed.
69. No concerns were noted about her throughout the night. Shortly after 7.00am the following morning, she was checked upon by the healthcare assistant. The other prisoners in the dormitory said she was sleeping and should not be disturbed. This was relayed to Nurse E. Nurse F arrived on Ivor ward for her duty at 7.25am. Before her hand over from the night duty staff, she began her routine roll check of all the prisoners. The check was always carried out at about the same time as the discipline officer grade staff do not start unlocking cells until approximately 8.30am.
70. When Nurse F reached the dormitory, of the four occupants only the woman appeared to still be asleep. She was in the first bed on the right when looking through the hatch. The other three women were awake and talking. The nurse could not see her face and so she asked Prisoner A to wake her up so that she could confirm that she was alright.
71. The prisoner initially refused saying that the woman needed her rest. The nurse insisted and so the prisoner reluctantly got out of bed and gently shook the woman's shoulder. The woman's back was towards her and there was no movement when the prisoner touched her. Seeing this, the other two prisoners jumped out of bed to check her as well. One of the women told the nurse that her body was cold.
72. The nurse used her radio and called a Code Blue emergency (recorded on the prison log as occurring at 7.40am) as the woman remained unresponsive. The nurse then ran to the office which is approximately ten to 15 metres away. She collected the blue emergency equipment bag (which contains a range of equipment to be used for resuscitation and in emergency situations), asked for assistance from the other nurses and for an ambulance to be called.
73. Two officers were on Ivor ward at the time. They were coming to the end of their night duty when the nurse raised the alarm which was also broadcast over the radio net. They made their way quickly to the cell where the other three prisoners had started to shout and bang the dormitory door. Officer H said that the women sounded distressed.
74. Officer I broke the seal on her key pouch and opened the cell door. The other prisoners left the room and the officer saw her lying in her bed. She went over to the side of her bed and started to call her name but got no response. She immediately started checking for ligature marks as she was unsure why she was unconscious, but said that she was "really cold". Officer H also described her as being "lifeless".

75. By the time the two officers had checked her for signs of life, Nurse F had returned to the cell. She was followed by two more nurses, who brought the oxygen cylinder and defibrillator machine. Having quickly examined her, Nurse F found that she was cold, blue, her tongue was sticking out of her mouth and her eyes were open. The nurse said that she showed no signs of life. Her left arm was constricted, bent and stiff which the nurse believed meant that she had been “dead for a while”. She told the officers present to call a Code Black (recorded as occurring at 7.42am). The nurse then started cardio pulmonary compressions (CPR), assisted by Nurse G.
76. Nurse G told the investigator that she had prepared the defibrillator machine for use. She cut the woman’s clothing and attached the pads to her chest. The defibrillator advised “no shock” and the two nurses continued with CPR. Attempts at resuscitation continued until the paramedics arrived. At the same time, Officer H took the other three prisoners, who were now standing in the corridor, to another room.
77. The Developing Prison Service Manager (DPSM) was in the Control Room when the Code Blue emergency alarm was called through. She quickly ran across to Ivor ward to assist. On route the emergency code was changed to Code Black (no signs of life). She arrived on Ivor ward about three minutes later. She saw the nurses attending to the woman. She took charge of the situation by appointing a log keeper (Officer H) to keep a record of events, ensured that the three other prisoners were supported and liaised with the staff. She also arranged to obtain further details about the woman so that they could be passed on to the ambulance crew.
78. Paramedics arrived at the cell at 7.48am, followed by a second paramedic crew immediately afterwards. Following their assessments, her death was pronounced at 7.50am.

After the woman’s death was confirmed

79. The death in custody contingency plan was put in place immediately by the DPSM. She contacted the duty Governor and the Head of Healthcare and other agencies. The cell was sealed to await the police, who arrived later that morning.
80. The prisoners were offered support from the chaplaincy team and members of the Independent Monitoring Board. The duty governor held a hot debrief in the Command Suite, which was attended by the staff involved in the morning’s events. The DPSM supported staff at the meeting, helped by the Safer Custody Officer. As staff had not found any ligature marks on the woman, they were unsure why she had died.
81. The DPSM told the investigator that the woman had not provided any next of kin details when she arrived at Holloway the previous day. She asked the prison telephone clerk to check the telephone records from her previous sentences. The police also agreed to try to identify and locate her next of Kin.

82. A prison family liaison officer (FLO) was appointed and attended the prison that afternoon to be briefed on the circumstances surrounding the woman's death. She told the investigator that a diary was found in her property which mentioned that she had three children, whose names were given to the police.
83. The next day, Monday 30 August, the police located the woman's step-father, who lived in Scotland, and informed him of her death. The FLO spoke to the step-father at 3.00pm. He said that he would inform her children of their mother's death. The following day, the eldest son contacted the FLO to ask for further information about his mother's death. He provided his mother's brother's contact details and said that he was the nominated contact point for her next of kin. The family were invited to visit the prison. The prison also offered financial assistance towards the funeral.

Post mortem

84. The cause of death noted in the post mortem report was morphine toxicity. It also made the following comment:

“Toxicological analyses have identified a concentration of morphine indicating recent use. Although not within the blood concentration range considered potentially fatal, it might theoretically have metabolised to a lower concentration in an unconscious/comatosed individual. In the absence of any other information or significant internal or external injuries, it is likely, on the balance of probabilities that death was as a result of the effects of morphine use. I would reserve the right to reconsider this opinion in light of any further information being provided.”

In referring to this report, the clinical reviewer said that:

“Information from the post-mortem indicated a death from an overdose of drugs, referred to as morphine toxicity. The post mortem discovered an enlarged liver and chronic inflammation of her kidneys which would indicate damage. However, in the comments section it notes that there was ‘no significant natural disease that could have caused or contributed to her death.’”

ISSUES

Clinical care

85. The clinical review was conducted by the clinical reviewer. His recommendations relate to healthcare matters and are directed to the Head of Healthcare and the Primary Care Trust.
86. Despite the concerns which he raises in the clinical review, he notes that, in general, prisoners receive a high standard of care on Ivor ward. He comments that the woman was seen promptly in reception when she arrived at Holloway and the correct procedures were followed for her transfer to the Ivor ward. Both these issues were considered as areas of good practice. She benefited from seeing staff who knew her from her previous sentences and were able to recognise that she was more poorly than before.

Reception

87. She had been in custody at Holloway on two previous occasions and, on both occasions, presented as suffering from withdrawal symptoms. On this occasion, she was clearly unwell and at times barely able to stand on her feet. She was seen by the reception nurse, who also knew her and her medical history.
88. The clinical reviewer notes that, when a patient is acutely physically unwell, alternative diagnoses and options for treatment should be considered. Her vomiting and fatigue could also have been due to Hepatitis C (of which she was a known carrier) or a gastric infection, but these possibilities appear not to have been considered. All the staff believed that her symptoms were the result of withdrawal from alcohol.
89. The clinical reviewer also points out that Holloway receives a high number of prisoners suffering from drug and alcohol misuse problems but the reception nurse had no formal training in the area of detoxification. I believe that this would be beneficial given that reception staff make the initial assessment of prisoners when they arrive.

The Head of Healthcare should ensure that training on detoxification and observation is offered to all the relevant staff.

Prescribed medication

90. There is conflicting information from the interviews and in the medical record as to what medication was prescribed and the woman received on Ivor ward. All the nurses from Ivor ward stated that she had been offered but refused domperidone to treat her sickness. The doctor had said that he prescribed carbamazepine, which might have relieved some of her symptoms. This was written on her medication chart but not on her prescription chart. The doctor was under the impression that she had been given these medications, but there

is no evidence of this in either the notes or on the medication chart. She was given a dose of chlordiazepoxide for alcohol detoxification (although the time at which this was given is not clear on the drug chart).

91. Prescribed medication was therefore not given according to the medication chart. There is no record why the medication was not given. Nurse C said that carbamazepine was not given because she had been vomiting, and would not take the domperidone suppository. This information, however, was not recorded in her medical records. When medication is not accurately recorded, this can lead to the possibility of a drug administration error. Omitting prescribed medication can also lead to worsening symptoms for the patient.

The Head of Healthcare should remind all nurses and doctors of the importance of accurate record keeping, including on the medication charts, and to notify relevant healthcare staff if a medication has not been given.

Assessing the woman's risk from misusing drugs

92. She was well known to staff at Holloway and was a known multi-drug user. It was also known that she had the potential to overdose when misusing alcohol or drugs. She was at risk of acute withdrawal symptoms because of her heavy substance use, and was showing possible withdrawal symptoms when she arrived at Holloway. It was not known exactly what drugs, and in what quantities, she had taken prior to arriving at prison. There was also no evidence to suggest she had received any unprescribed drugs whilst in custody. Healthcare staff also did not know if, and how many times, she might have vomited prior to arriving at the prison. I suggest that all of this information should have been considered by staff together with the fact that she had known physical illnesses including kidney failure, hepatitis A, B, C and HIV.
93. The clinical reviewer questions whether she could have been observed more frequently by staff and if her risk category should have meant that she needed closer observation. He comments that this was especially important given that patients on an alcohol detoxification regime using chlordiazepoxide normally need "close observation" in the first 24 hours.
94. The Department of Health guidelines which refer to the clinical management of drug dependence in the adult prison setting, state that "Patients must be monitored frequently during the stabilisation and detoxification phases to ensure that symptoms are controlled". The guidance also makes reference to uncontrolled vomiting during detoxification in prison and, if this symptom were to persist beyond a period of 24 hours, the prisoner must be transferred to an outside hospital.
95. I agree with the clinical reviewer that admission to hospital should have been considered. Interviews with healthcare staff, including the prison doctor, provide no evidence that consideration was given to admitting her to hospital and the opportunity was missed.

96. The Department of Health guidance does not specify what level of observations should be undertaken overnight. This is primarily because individuals vary and the observations should be assessed on a case by case basis. She was observed overnight, through the doorway hatch of the dormitory, in accordance with the prison's healthcare and security protocols. The frequency of the checks is not documented.
97. I appreciate that the women who arrive at Holloway often have complex needs. I am aware that on their first night, multi-drug users are sometimes kept in a single cell if a potential for overdose is identified. Consideration should therefore be given to making this practice routine for prisoners who need close observation. I also believe that for someone presenting with as many risk factors as her, it would be reasonable to suggest that a minimum of hourly monitoring through the open hatch was undertaken and documented.

The Head of healthcare should review the policy for the referral to outside hospital for new prisoners into custody, who arrive presenting with acute physically unwell symptoms.

The Head of Healthcare should ensure that staff record their observations of prisoners going through the detoxification phases.

Person Escort Record

98. The PER is the key means of ensuring that information about the risks posed by prisoners on external movement from prisons is available to those responsible for their custody. In the woman's case, it was noted that she had a number of current physical health risks. There was however no mention of her being sick or receiving medication in police custody. No reference was made either to her possible drug and alcohol intake and she was sick again soon after leaving police custody.
99. It is important that, as far as possible, all the information about a prisoner's state of health is recorded by the criminal justice agencies which come into contact with them and that it is passed on to those who are subsequently responsible for a prisoner's well being.
100. Prison Service Order (PSO) 1025, issued on 1 May 2009, introduced a new PER document to be used when escorting prisoners within the criminal justice system. The form provides a space for to ensure that all the relevant information regarding risk is commented on fully within the document, in contrast to the previous form, on which only a box needed to be ticked. For whatever reason, the new PER form was not used during her time in custody. Had it been used, there might have been an opportunity to provide more information about her current risks.
101. It is essential that all escort staff and receiving agencies are equipped with information, particularly information about risk, relating to a prisoner prior to and during the escort procedure. The current method of achieving this is the revised PER, and this is the form that should be used.

The Nation Offender Management Service should ensure that the escort contractors use the new style (A4) PER as set out in PSO 1025.

Staff response to the emergency

102. The staff response to the emergency call was immediate. It was helpful that two officers were only yards away from her cell when notified to open the cell. All emergency equipment was taken to the cell and cardio pulmonary resuscitation was carried out immediately by healthcare staff.
103. The guidance provided in Prison Service Order (PSO) 2700 Annex 13A, says that resuscitation must be attempted unless rigor mortis has clearly set in. The onset of rigor mortis was evident from the nurse's examination of the woman, who believed that she had probably been dead for some time. The efforts of staff certainly wanting to try and resuscitate her are noteworthy. In such instances however, staff should be reminded of maintaining the dignity of the deceased as much as possible. I bring this issue to the attention of the Governor and Head of Healthcare who may wish to remind staff of the principles of PSO 2700.

The Governor and Head of Healthcare should remind staff of the principles of PSO 2700 when responding to a potential death in custody. Where clear clinical judgement has been made that resuscitation would be futile, staff should refrain from attempting cardio pulmonary resuscitation, as to maintain the dignity of the prisoner.

CONCLUSION

104. The woman arrived at Holloway, already an unwell woman, and it was not clear exactly what quantity of drugs and alcohol she had taken. The fact that she had a number of physical illnesses would have also had an impact on her presentation. Staff knew of her medical history, and treated her immediately for drug and alcohol withdrawal. However, there is little mention of her physical ailments and no mention at all of whether referring her to outside hospital was considered. This may not have changed the outcome, but it would have meant that more frequent checks being made and she would have been treated by specialist hospital staff.
105. Given the seriousness of her state of health, it should have been imperative that staff ensured that any treatment she was prescribed and received was noted accordingly, to ensure a continuity of her observation and care.
106. I agree that it is difficult to treat an individual who arrives in custody in the manner that she did and with her medical history. She herself knew the routine of being admitted to Holloway and the process that would be carried out to try and make her feel better. This seems to have been what she wanted to happen. I do not think that she really knew how potent her misuse of drugs and alcohol was or whether she, or indeed the prison healthcare staff, realised that it would result in her death.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that training on detoxification and observation is offered to all the relevant staff.

The National Offender Management Service accepted this recommendation, writing:

“Training opportunities for detoxification management and monitoring is provided to all relevant staff by the Healthcare provider. All relevant Healthcare staff are required to attend such training. A programme for such training was in effective operation at the time of the woman’s death, with the majority of relevant staff already trained. We will continue with this programme.”

2. The Head of Healthcare should remind all nurses and doctors of the importance of accurate record keeping, including on the medication charts, and to notify relevant healthcare staff if a medication has not been given.

The National Offender Management Service accepted this recommendation, writing:

“HMP/YOI Holloway’s Healthcare provider had a Record Keeping Policy in place at the time of the woman’s death. This remains in place. The policy is complemented by an audit schedule to ensure the requirements of the policy are adhered to. All medication errors are reported by the provider’s incident reporting mechanism, and all staff who have been involved in such an error are given training in the administration of safe medication by the Pharmacy Department.”

3. The Head of Healthcare should review the policy for the referral to outside hospital for new prisoners into custody, who arrive presenting with acute physically unwell symptoms.

The National Offender Management Service rejected this recommendation, writing:

“Like with the woman’s reception to Holloway, when women arrive they are seen by a Healthcare Assistant, Nurse and a GP. The decision on whether any individual needs to attend to outside hospital is a clinical one, undertaken by the professionals we mention. The assessment of the professionals with regards to her was that her clinical needs could be met within HMP/YOI Holloway’s substance misuse Unit. We are satisfied that the Healthcare professionals involved in the decision making processes at the time of her death, and remaining in place, are qualified to make such decisions. We do not assess there to be a need for a distinct policy since it is intrinsic within the roles of our Medical professionals to ensure that the required care is provided to our women at all times, making such decisions as whether admission to outside hospital is required on a routine basis.”

4. The Head of Healthcare should ensure that staff record their observations of prisoners going through the detoxification phases.

The National Offender Management Service accepted this recommendation, writing:

“We believe there is clear evidence that this was completed for her, and are confident that this is effectively in place for women admitted to our detoxification unit. We will continue with current practices. “

5. The Nation Offender Management Service should ensure that the escort contractors use the new style (A4) PER as set out in PSO 1025.

The National Offender Management Service accepted this recommendation, writing:

“Prison Escort Contract Services (PECS) has instructed both GEO Amey and Serco Wincanton that the new style PER as set out in PSO 1025 must be used and that any stocks of the old style PER must be destroyed. “

6. The Governor and Head of Healthcare should remind staff of the principles of PSO 2700 when responding to a potential death in custody. Where clear clinical judgement has been made that resuscitation would be futile, staff should refrain from attempting cardio pulmonary resuscitation, as to maintain the dignity of the prisoner.

The National Offender Management Service accepted this recommendation, writing:

“The Head of Residence/Safer Custody Team Leader and Head of Healthcare will issue briefing packs to relevant staff. These will be issued at appropriate intervals. “

“The local Death in Custody and Suicide Prevention and Self Harm Management Policies will also be updated with appropriate guidance. Staff in all disciplines will be periodically reminded of the location of these policies and tasked to be familiar with the contents.”