Circumstances surrounding the death of a woman in September 2005 at Hospital, while a prisoner at HMP Bronzefield

Report by the Prisons and Probation Ombudsman for England and Wales

November 2006

This is the report of an investigation into the circumstances of the death of a woman who died at Hospital in September 2005 while in custody at HMP Bronzefield.

I extend my sincere condolences to the woman's family and friends for their loss.

I would like to thank the Director and her staff of Bronzefield for their co-operation with this investigation. I am particularly grateful to the Head of Operations and Security for her assistance. I have found the prison's contact with the woman's family to have been both sensitive and respectful.

I am required to investigate all deaths of prisoners – whatever the cause. As in a number of other reports following deaths from natural causes, this investigation has raised some very significant issues for the prison concerned and for prisons generally.

The woman had been suffering from heart disease and the post mortem confirms she died of a heart attack. However, the clinical review concludes that, if staff had been more aware of her medical history and more familiar with local and national policies, they might have acted more appropriately on the night she died.

I have made a large number of recommendations. They are primarily directed to the improvement of healthcare services at Bronzefield. I am pleased to say that, following the publication of the draft version of the report, all the recommendations have been accepted by Bronzefield and I enclose their comments in the recommendation section of the report.

This report has been slightly amended to provide an anonymised version however, it is, in essence the same as the final report.

Stephen Shaw CBE
Prisons and Probation Ombudsman **November 2006**

CONTENTS

SUMMARY

The woman who died was remanded to HMP Bronzefield in August 2005. She appeared at court again later in August and further remanded until September. On arrival at Bronzefield, the woman's health was assessed by a nurse. It was recognised that she suffered from heart problems and was due to have a heart by-pass operation in September.

Neither the woman's GP nor her cardiac consultant was contacted for information on her current condition, upcoming surgery or past medical history. This was despite the fact that she had informed staff that she was awaiting major heart surgery. It was documented several times that her GP should be contacted. It appears that staff did not fully appreciate the seriousness of the woman's medical condition and therefore the clinical care required.

Early on a morning in mid September, the woman rang her cell call bell. When the wing officer went to the woman's cell, she found her sitting up and breathing into an empty crisp bag. The officer believed the woman said she as having an asthma attack. Conversations with staff in the communication room ensued and they told the officer that the woman had said she was having a heart attack. The response nurse and Night Orderly Officer were asked to attend the cell, but were not told the nature of the emergency call.

The wing officer checked on the woman again and found her collapsed on the floor. After waiting for the Night Orderly Officer to arrive, the response nurse and the wing officer then entered the cell and began cardiopulmonary resuscitation. This was continued until the paramedics arrived at 4.06am and took over her care. The woman was subsequently taken to a local Hospital. Sadly, she did not respond to the resuscitation attempts and was pronounced dead at 4.45am. She was aged 48.

The clinical review conducted as part of this investigation concludes that some of the woman's care was less than satisfactory. Had staff had been more aware of her medical history, and more familiar with local and national policies, they might have acted more appropriately on the night and put themselves in a better position to manage the emerging situation.

The woman's family was informed of her death promptly, the news being broken to them in person by the Director, the head of healthcare and the chaplain. The prison's liaison with her family has been very well handled.

THE INVESTIGATION PROCESS

1. My investigator formally opened the investigation at Bronzefield in October 2005. She met a member of the Independent Monitoring Board and visited the wing where the woman had lived. She was also provided with staff incident reports written at the time of the woman's death as well as other records relating to her time in custody. She returned on five further occasions, accompanied by the clinical reviewer to see CCTV footage and interview staff.

2. Before the interviews were conducted notices were issued to staff and prisoners announcing the investigation and inviting anyone who had relevant information to make themselves known to the investigation team. In the event, nobody came forward.

3. One of my Family Liaison Officers contacted the woman's family to explain the purpose of the Ombudsman's investigation and to discuss any questions the family might have. They accepted that she was suffering from a severe illness that could at any time have become critical. They did not feel they had any particular concerns about her time in Bronzefield and did not wish to meet with any of the team. However, they requested a copy of this report when it was available.

4. In addition to the independent clinical review of the healthcare the woman received whilst in custody, by a clinician who works for my office, an employee of the Department of Health, who is responsible for the detoxification programme in the female prisons, was consulted regarding the woman's treatment and care for substance misuse.

5. My investigator contacted Her Majesty's Coroner to inform him of the nature and scope of the investigation and to request a copy of the Post Mortem report. Upon completion, this report will be sent to the Coroner to assist him in his enquiries.

6. Six formal interviews with staff were conducted. This report is based upon those interviews, a thorough examination of all relevant records, and my consideration of the findings of the clinical reviews.

BACKGROUND

The woman

7. Born in 1957, at the time of her arrest, she was living with a partner in Dover having been divorced a number of years before. She had four grown-up children. The woman had been in prison briefly before, both at Holloway and Bronzefield.

8. The woman's physical health was poor. She was receiving treatment for a heart problem and many other conditions. She was taking various prescribed medications, as well as illicit substances. The woman also reported a history of self-harm and explained that she had been treated for schizophrenia in the community.

9. During her time at Bronzefield, the woman worked as a cleaner and was described as a polite person, interacting well both with prisoners and staff. She chose to live on houseblock 3, preferring that to the healthcare centre where perhaps, given her ill health, she would have been more appropriately located.

10. The woman had numerous friends, many attending the memorial service held for her at Bronzefield.

HMP Bronzefield

11. HMP Bronzefield opened on 17 June 2004. It is a purpose built woman's prison privately operated by UKDS. Bronzefield performs the role of a local prison, taking prisoners directly from the courts. Additionally sentenced woman may serve some or all of their sentences there.

12. Accommodation is provided in three house blocks, with mostly single cells. There is a mother and baby unit, a high-dependency unit and a separation and a care unit.

13. The healthcare centre provides 18 in-patient beds. Primary health care is commissioned from UKDS' own services with the exception of the Community Mental Health Team, which is commissioned from the local PCT. There is 24 – hour nursing cover and a doctor is available on site from 10am to 5pm, with additional on call services outside of these times.

14. The first inspection of Bronzefield took place in June 2005. It was noted that overall the inspection was positive, taking into account the steep learning curve the prison had undergone in a short time. The inspection team were impressed with the enthusiasm of managers to take on board their proposals and learn from their experience. However, they pointed out that a critical task for managers would be to ensure that a relatively inexperienced staff team were sufficiently supported.

15. The woman was the first prisoner to die at Bronzefield since its opening. Another prisoner died there from natural causes just four weeks after this death. That death is also the subject of an Ombudsman's investigation. In one other case, a woman died in July 2004, within a few hours of being released from Bronzefield; my office also investigated her death.

KEY EVENTS

Events up to the woman's death

16. The woman was remanded to Bronzefield in August 2005, and was expected back in court later that month. She underwent the usual first night in custody procedures including seeing a nurse for a First Reception Health Screen. The reception nurse noted that he woman had been in prison before and that she had several physical health issues, including awaiting a Coronary Artery Bypass Graft (CABG). The woman told her she was due to have this operation in late September 2005.

17. She also told the nurse that said she was taking several types of prescribed medication, but could not remember the names of each drug. She reported that she had problems with asthma, chest pain and allergies. Importantly, she informed the nurse that she was allergic to aspirin and penicillin. The woman was known to misuse illicit drugs and a urine drug screen proved positive for heroin, cocaine and THC (the active ingredient in cannabis). She was referred to the doctor regarding her physical health, substance use, and for a mental health assessment. The reception nurse made a note in the woman's medical record detailing all of the above and recommending she be located in the healthcare centre for observation.

18. In interview, the reception nurse remembered seeing the woman on that first evening -she described her as quite ill, but managing. She also said that the woman had been to Bronzefield before. She said that she did not want to be admitted to healthcare, as she had spent some time there previously and found it so disruptive that she could not sleep. Nevertheless, the reception nurse remained of the view that the woman should be located in the healthcare centre. In the event, the woman was located on a houseblock and not in healthcare. When asked about how this had occurred, the reception nurse explained that she did not have any input into this process. She said she would make a recommendation about where each woman should be allocated; however, the final decision lay with the officer that evening.

19. The doctor saw the woman the next day. A list of her medication was compiled and a note made requesting that the nurse contact the woman's GP to check the details of this. A brief note was then made of her past medical history and current clinical presentation, including the fact that she said she was awaiting open-heart surgery. The woman was started on a methadone maintenance programme of 25mls issued once a day, and a further note was made to admit her to the detox wing.

    When prescribing methadone without supporting evidence of a prescription, every attempt must be made to titrate the dose to meet the presenting symptoms of the individual.

20. The woman's personal record shows that she had an initial resettlement plan completed a day later. This is a poorly completed document with several sections incomplete and no referrals made to support agencies; this appears to have been because the woman was due back in court soon. However, this form should have been completed regardless of her position. In point of fact, the woman referred herself to the drug service on 26 August.

21. A week later, the woman was seen by another doctor, who noted again that she was awaiting a coronary artery bypass graft. The doctor's notes read:

    "see IMR' IMR notes state allergic to aspirin. To contact GP for details of allergies and details of CABG etc. ?date of surgery"

22. Two days later, the woman was seen by the substance misuse doctor. The records show that she was due to go to court soon for sentencing and was possibly looking at a sentence of five years. There were notes made detailing the drugs she had been using. These included heroin which she said she had smoked for 16 years, claiming use of about £70-80 a day. It is also recorded that she had not drunk alcohol for six years, but in the last three months had started again and was drinking 20 pints of Tennants Extra a day. The woman also said she had been buying methadone, 50mls a day. Again it was noted that the woman was awaiting heart surgery and a cholecystectomy. As a result of this appointment, a plan was developed to maintain the woman on her methadone programme until she was due back in court. It was then planned to start her on a methadone detoxification programme.

23. The next entry in the woman's clinical records, incorrectly dated, shows that she was seen in the nurse's triage clinic complaining of "feeling unwell". She was apparently itching all over her body and her legs appeared swollen. The woman stated that she was not sleeping and was feeling tired. She also said her anti-angina spray (GTN) was not working. She was appropriately referred to see the doctor.

24. On 8 September, the substance misuse doctor saw the woman again. It was again documented that she was going to court and then to Hospital for her operation soon. It was noted that the woman was on methadone maintenance plan, and this should maintained at 25ml a day until she came back from hospital. There is no evidence of any communication between the prison and the Hospital. This would have been important as it would have facilitated a seamless and holistic approach to her care.

    The Director must ensure that a clinical policies and procedures manual is available for all staff. Healthcare staff must be reminded to follow agreed policies at all times and should ensure that they remain up-to-date in accordance with the code of professional conduct.

25. A probation officer saw the woman in early September. She noted the woman's drug use and they talked about several issues. The woman told her she was due back in court soon.

26. In mid September, the woman saw the doctor again and told him she thought that she had suffered a mini heart attack the previous week. She also said she had got the wrong asthma pump. Her particulars were once again noted and the doctor documented that she was not distressed and had no current pain. She was apparently advised on the correct use of her inhaler. It seems she was also given a week of authorised excusal from work. The woman's vital signs (blood pressure and pulse) were noted as being within normal limits. This is the last entry in the clinical records.

27. The woman's personal record is sparse. It observes that she was seen in reception in August and completed her induction one week later. It further records that she was "issued with her cell key … is on a standard regime … and seems happy on C wing." There are nine entries in all, the final dated mid September, remarking: "seems to be ok on C spur. Usually polite and compliant."

The night the woman died

28. At night, the Orderly Officer (Oscar 1) and the Assistant Night Orderly Officer (Oscar 2) carry a full complement of keys giving them access to all areas of the prison. Additionally, two officers patrol the boundaries of the prison. They both carry all keys except a cell key, allowing them access to all areas except prisoners' cells. The officers on each houseblock carry an emergency pouch containing a cell key. These officers are locked on to their houseblock, but can use their cell keys to enter cells in an emergency. There are also two nurses on duty at night. One is stationed on the detoxification unit and is provided with an emergency pouch only. The second nurse is referred to as the 'response nurse'. It is the response nurse's job to respond to any emergency or call out anywhere in the prison. The response nurse holds a full set of keys and can therefore gain access to all areas.

29. The wing officer usually worked on houseblock 2. However, on this evening, she was allocated to work on houseblock 3. The cell bell log shows that the woman rang her call bell at 3:36am in the morning. The wing officer said that she answered the bell in the office on the central hub, but it cut out abruptly. She said that, soon afterwards, she received a phone call from the communications room officer. If a call bell is not answered on the houseblock within a certain amount of time, it is diverted to the Communications Room where staff can talk to prisoners via an intercom. The wing officer said she would go to the woman's cell. She explained that, as she approached the cell, she heard banging and someone shouting, 'Help me.' The wing officer said she looked into the woman's cell and saw her sitting on the toilet breathing though a crisp bag. The woman told her that she was having an asthma attack. The wing officer said she told the woman she would go and fetch help.

30. The wing officer returned to the hub and phoned the Communications Room. She told the communications room officer that the woman was having an asthma attack. She said the communications room officer insisted that the woman was having a heart attack and asked her to check her again. The wing officer returned to the cell and found the woman lying on the floor. She could see that she was breathing as "her stomach was going up and down". The wing officer then returned to the hub and phoned the Communications Room yet again. She

requested a nurse and Oscar 1 attend. The wing officer returned to the cell and watched the woman through the hatch. The response nurse arrived and they waited for the Night Orderly Officers to arrive to unlock the cell door.

31. The communications room officer is the central point of contact for staff on duty during the night. It was her role to relay messages between staff and to respond to any emergency by implementing the relevant contingency plan. Her recollection was that the woman rang her cell bell at 3.47am and she answered it. She said the woman said, "Help me please, I am having a heart attack." The communications room officer called the wing officer on the telephone and told her that the woman said she was having a heart attack. The wing officer told her that she had just been to the cell and believed that the woman was having an asthma attack or having breathing difficulties. The communications room officer repeated that she believed that the woman was having a heart attack and the wing officer agreed to go back to the woman's cell and check on her. The wing officer called her back after checking the woman again and they discussed what they should do. She said:

    "We did debate for a second, because I was a bit, didn't know what to do and then I think, we both decided amongst ourselves that obviously tell the orderly officer. So I then phoned the Night Orderly Officer about possibly 3:48am and advised him of the situation, he then advised me to get a nurse to … the houseblock".

32. The communications room officer said she told night orderly officer that the wing officer believed the woman was having an asthma attack, but that she had heard the woman say she was having a heart attack. The night orderly officer advised her to get a nurse and she called for the response nurse over the radio. She noted in the control room log that she called the nurse at 3:49am and that the nurse arrived on the houseblock at 3:51am. The communications room officer explained that she used the Communications Room clock to record the time in the log. She appreciated that this clock did not give the same time as the various computer screens.

33. The response nurse said she was called from the Communications Room at 3:40am and asked to attend houseblock 3. She called the Communications Room back to ask what the nature of the emergency was and was told someone had collapsed. She was still unsure of exactly what type of incident she was attending. However, she grabbed her emergency bags and went to houseblock 3.

34. Houseblock 3 is approximately 200 metres from the healthcare centre and she estimated it took two to three minutes to get there. The response nurse said she immediately went to look at the woman through her hatch. The woman was lying on the floor but moved slightly so she could see that she was breathing. She noted that there was no ligature around her neck. She knew the Night Orderly Officers were on the way, so waited for them to arrive to unlock the cell.

35. The night orderly officer said he remembered that the communications room officer contacted him by phone at 3:48am. He said she explained that she had had a call from a woman and that she was in quite a bit of distress and thought he

should go over to the houseblock. He believed the response nurse had already been called, as she was already on the house block when he and the assistant night orderly officer arrived there. The night orderly officer said his office was situated just two to three minutes away from houseblock 3, and it did not take him long to get there.

36. The night orderly officer said that he was not given the impression from his discussion with the communications room officer that there was an emergency. He said:

> "My initial understanding of it was that it wasn't a medical emergency, it wasn't a life threatening situation because of the call I'd got from the auxiliary I think, that she had heartburn or something, nothing was mentioned that she'd got chest pains and felt faint, or anything. Then obviously we would have stepped it up a bit."

37. The night orderly officer said he saw the woman lying on the floor of her cell. The response nurse told him she could see the woman breathing, so she did not deem it necessary to go straight into the cell. He believed that if the woman had not been breathing the nurse would have entered the cell earlier. He remembered saying "have you not gone in yet?" and the response nurse replied that the woman was still breathing.

38. The night orderly officer then followed the prison's procedures for entering a cell at night. He unlocked the woman's cell, but did not undo the bolt. He then took all the keys to the hub office and secured the spur. He then gave instructions for the assistant night orderly officer to enter the woman's cell, which he did.

39. The response nurse then entered the cell and could not get a response from the woman. She said:

> "Her breathing was really, really slow, very silent ... and her pulse was really feeble... I could see her getting cyanosed, getting blue."

40. The response nurse began cardio pulmonary resuscitation and asked the wing officer to help her. She performed cardiac massage while the wing officer did the respirations. She then asked for an ambulance to be called and for the other nurse to attend. She said she did not know the woman's medical history and it would have been helpful to have someone check her medical record for her. The response nurse thought the wing officer was "struggling", and she had to help her while simultaneously performing heart massage on the woman. She felt the wing officer tried her best but was "panicking".

41. The reception nurse was the nurse detailed to work on the detox wing that night. She was aware "something was going on" because she had heard some of the conversation over the radio. However, she was unclear what the nature of the emergency was and which emergency equipment to take with her. As she did not have a set of keys, she waited for the assistant night orderly officer to collect her and escort her to the woman's cell. When she arrived at the cell, she took over cardiac massage from the response nurse and the response nurse relieved the wing officer. She also arranged for blood pressure readings to be taken. She

said that at this point the woman's lips and extremities were blue, but her body was still warm.

42. The assistant night orderly officer explained that another prisoner was on long-term bed watch that night. Two members of staff were dedicated to the bed watch, reducing the night staffing complement by two. The assistant night orderly officer and the night orderly officer were in the duty office when they had a phone call from the communications room officer. She told them that she had taken a call from a woman who said she was having trouble breathing. The woman was apparently using a crisp packet to control her breathing and it was therefore thought she was having an asthma attack.

43. The assistant night orderly officer presumed that the wing officer was doing F2052SH (self harm) observations when the woman had rung her cell bell, and that was why the call had gone though to the Communications Room. He said the communications room officer was instructed by the night orderly officer to contact the wing officer. A short while later, he heard a call over the radio to Hotel 2 (the response nurse) to attend the houseblock. At this stage, he and the night orderly officer prepared to go over to the houseblock.

44. When they arrived at the woman's cell, it was clear that the response nurse had decided not to go into the cell. He thought she said something about seeing movement and therefore had not been overly concerned. They then observed the procedures for opening a cell at night and the response nurse went in. She checked for vital signs and realised the prisoner was unresponsive. She then asked for the other nurse and an ambulance to be called. He collected the second nurse and returned to houseblock 3. He was then asked to go to the gatehouse and prepare the way for the ambulance to gain access by the quickest route.

45. According to the control room log, the ambulance was called at 4:01am and arrived at the gate at 4:06am. It arrived at the houseblock at 4:12am, escorted by the assistant night orderly officer. The paramedics took over resuscitating the woman and moved her to the ambulance. They left the spur at 4:28am and the prison at 4:34am. Further efforts to revive the woman were made in the back of the ambulance, but sadly she was pronounced dead at 4:48am at the local Hospital. The subsequent post mortem has identified that cause of death as a myocardial infarction (heart attack).

The prison's response to the woman's death

46. The Death in Custody incident log was started at 4:48am and the Director, the Controller and the Prison Service were promptly informed. The Independent Monitoring Board, the chaplain, and the head of healthcare were also notified. The Director arrived at the prison at 5:43am.

47. The woman had named her partner as her next of kin. The Director, the chaplain and the member of staff who acted as the family liaison, drove to Dover later that morning to break the news to him. However, he believed that the woman's son should be treated as the next of kin. At that time, he was in HMP Rochester. The Head of Operations and Security, therefore contacted the duty governor at

Rochester and advised him what had happened. The duty governor and chaplain then went to see the woman's son and broke the sad news of his mother's death to him.

48. The director of Bronzefield promptly wrote to the woman's son offering her condolences and reassuring him of the support he could expect from Bronzefield. He replied thanking the Director and included a note to be read at his mother's memorial. Further letters were exchanged between the woman's son, the Director and the chaplain. A memorial service was held at Bronzefield in later September.

49. A hot debrief was held for staff on the day following the woman's death. This was chaired by the Head of Operations and Security. At interview, all staff felt they had been adequately supported, with the exception of the night orderly officer. He said that enquiries had been made of him regarding the other staff, but no one had asked how he was coping.

    The director should remind her senior management team of their responsibility to care for all staff in the aftermath of a death in custody.

ISSUES

The woman's medical care

50. The clinical review makes detailed observations on the woman's medical care. I endorse the recommendations made by the reviewer. In particular, I would like to highlight a number of points.

51. It is evident that in the short time that the woman was in Bronzefield she made it clear to staff that she had a number of on-going clinical problems. I am critical of the way that Bronzefield dealt with this information. First, a note was made to contact her doctor, and this was important because of the seriousness of the woman's condition and the number of different prescribed medications she was taking. There are further entries in her medical record requesting that her prescriptions should be checked, and an update on her clinical condition obtained from her GP and the consultant. However, none of these requests seems to have been actioned, despite the frequent notation. It seems that she was also awaiting a cholecystectomy, but again this does not appear to have been investigated.

    When a prisoner presents with any previous medical history or reports that they are receiving prescribed medication, information regarding medical history and current prescribing must be obtained from the GP or hospital.

    Where a medical history is requested but does not arrive, this must be pursued until the information is obtained.

52. There is no note in the medical record to explain whom the doctor meant to contact the GP and it appears from the record that no-one did so. At this stage, it seems that the healthcare professionals were not fully aware of the woman's cardiac condition and the treatment which she was due to have at the hospital and made no practical attempt to find out this information. Furthermore, there does not appear to have been any effort to obtain the woman's previous prison medical records.

    Where there have been previous admissions to prison, the medical record for the past periods in custody must be obtained.

53. I am particularly critical of the lack of communication with the Hospital where the woman was due to undergo major surgery. I have little doubt that contact with her consultant could have facilitated a more holistic approach to her care. More importantly, it seems no effort was made to confirm that the surgery was in fact due to take place or what was required by the hospital in terms of pre-admission preparation.

54. The woman reported a past history of schizophrenia and of self-harm, but this does not appear to have been followed up anywhere.

55. When the woman tested positive for methadone, best practice would dictate that the methadone prescription should have been titrated, but this too did not happen, the woman was prescribed 25mls a day to be taken in one single dose.

56. Despite the information supplied by the woman, no further assessment was made of her alcohol intake. At the very least, this should have been explored in more detail and, if required, an alcohol detoxification programme should have been prescribed to run along side her methadone programme.

    The First Health Reception Screen form must be read carefully by the GP and used as a basis for the meeting with the prisoner. All physical, psychological and drug related health issues declared on the form must be discussed with the prisoner and further clinical information obtained to establish an appropriate management plan, including clinical tests and treatment.

57. The woman was not referred to any internal or external agencies or services. As a minimum, she should have been referred to the local drug services and other support services by both the clinicians and the resettlement worker. As we know, she in fact referred herself to the drug support services.

    For prisoners with a significant past medical history, the information given during the First Health Reception Screen and subsequently to the doctor should form the basis of a nursing plan which is designed to meet the requirements of the patient.

58. The defibrillator was not taken to the cell, when healthcare staff were alerted. The response nurse said staff did not automatically take the defibrillator with them when called out. She explained that staff had two emergency equipment bags to carry and it was impossible also to carry the defibrillator. She added that she had not been trained in use of the defibrillator, although she had used them in previous posts and believed she could use one if she needed to. She acknowledged that there was an accepted practice of not taking the defibrillator and this may be because other staff were not trained in its use or confident of using it.

    A professional training and development needs analysis must be carried out to identify the training needs of all staff working in healthcare.

    Staff on professional registers must be reminded that they have a personal responsibility to maintain their continued professional development.

59. The woman said during her First Reception Health Screen, and it is clearly documented, that she was allergic to aspirin and penicillin. Despite this, she was prescribed aspirin 75mg. The prescribing doctor failed to note her allergies or her medical condition, namely asthma, in which non-steroidal anti-inflammatory drugs are contraindicated. The nurses administering the medication also failed to check the allergies noted on the front of her chart. Following the prescribing of the aspirin, there is an entry in the drug chart that states ‘refused’. There is no nursing documentation relating to this in the continuous medical record. If a

patient refuses medication, a note should always be made in the clinical records giving the reason for the refusal.

An audit of record keeping practices at Bronzefield against NMC and GMC standards should be undertaken. It should include the use of contemporaneous nursing records and care plans for the acute period of stabilisation and for a prolonged period where concurrent physical symptoms persist.

Clear, precise and accurate information must be documented in the clinical records including care plans and vital signs observation charts, to ensure that all multidisciplinary team members are aware of the treatment administered.

If a patient refuses prescribed medication, a note should be made in the clinical records regarding the reasons for refusal.

60. When the woman complained of feeling unwell in early September, the nurse decided that she needed to see the GP regarding her medication. However she was not seen by a doctor for three days and it appears that it may have been a routine follow-up with the substance misuse doctor. The woman should have been referred immediately, particularly given the medical advice that patients on GTN in the community should call 999 if the spray does not work after the third dose.

Nurses should be reminded that patients with coronary problems, when presenting with medical symptoms such as swollen legs, itchy skin and angina medication not working, should be referred to a doctor for medical opinion as quickly as possible.

61. I am also critical of the decision not to locate the woman in healthcare given her serious ill health and the potential for a sudden deterioration in her condition at any time. I understand, of course, that the views of any patient must be considered in such circumstances. However, I am troubled that the reception nurse's belief that the woman should have been located in healthcare for observation was overridden or ignored.

In accordance with by the principles set out in the Nursing and Midwifery Council's code of professional conduct, communication between the members of the healthcare team should be encouraged. As part of this, multidisciplinary team meetings and discussions should be considered to improve continuity of care.

62. The clinical review identifies a number of additional learning points for the prison, including regular checks of vital signs when blood pressure is outside normal limits and the use of observation charts to ensure such checks are completed.

Baseline clinical observations of temperature, pulse and blood pressure must be undertaken on every new admission requiring clinical substance misuse management for at least the first 72 hours as indicated in PSO 3550.

Any abnormalities in temperature or blood pressure recordings should be monitored until stable for a period of several days and the patient reviewed by a doctor.

The response to the woman during the night she died

63. It seems there was confusion between the wing officer and the communications room officer. Both staff members talked to the woman, but each understood the problem to be quite different. My investigator viewed the CCTV footage and it is clear that the two staff members spoke several times over the phone before they made a decision about what they should do. In interview, the wing officer could not clearly remember how many conversations she had with the communications room officer or all of what was said. She said she had also made other calls to check the orderly officers were on their way. I note the view of the clinical reviewer that the inexperience of the custody and auxiliary officers played a significant part in what occurred.

64. It is manifest that communication with the orderly officers resulted in further confusion. They clearly believed that they were not facing an emergency situation. Consequently, their response was not what it would have been had an emergency been called. The night orderly officer and the assistant night orderly officer said that the initial call they received did not reflect the gravity of the situation. Had it done so, they would have acted differently. It was not until they got to the spur that assistant night orderly officer said the situation seemed to have escalated. If a code blue had been called, both officers were adamant that they would have dropped everything and gone immediately to the residential unit.

The Director must ensure that staff are aware of, and adhere to, the use of emergency "codes". All staff should be advised of the meaning of the codes and in what circumstances to use them. They should be reminded of the proper use of radios and the need to use earpieces where appropriate.

65. The communications room officer called the nurse to the wing. However, possibly 8-10 minutes had already elapsed before this action was taken. Whilst the nurse arrived quickly, I am disappointed there was still further delay before they entered the woman's cell. When questioned about this the wing officer explained:

"I thought that I'm only allowed to open it if it's someone hanging or someone's that's dead, but because she was breathing I thought I shouldn't open it."

66. I have no doubt that the wing officer genuinely believed she should not enter the cell unless it was an extreme situation. However, the decision she took must be criticised as representing an excessive regard for security over patient care.

67. The response nurse said that, when she arrived on the wing, the wing officer was panicking. She tried to reassure her as she observed the woman through the hatch. When asked why she did not enter the cell immediately, she explained

that she could see the woman was breathing and therefore, for safety reasons, felt she should wait for the orderly officers to arrive. She said she would have opened the cell herself and gone in directly if a code blue had been called, or if she had known the woman's clinical history.

68. Neither the officers nor the nurse were aware that the woman had a diagnosed cardiac problem and was awaiting a coronary heart by-pass. The response nurse said in interview that, had she been aware of this, she would have entered the cell immediately. However, she also mentioned the difficultly in having another member of staff access the woman's medical records to provide such information. She explained that during the night shift she is supported in the healthcare centre by an auxiliary officer. Because of patient confidentiality, she believed they are not allowed to access patient notes. In other words, she would have had to wait for the second nurse to access this information or have gone back to the healthcare centre herself. Department of Health guidelines are clear about disclosure of such information in emergency situations. It is perfectly reasonable to allow access to confidential information where the information can be used to help inform the care given to the individual, particularly in an emergency situation.

    A policy on sharing of crucial information should be developed as a matter of urgency in accordance with the Department of Health guidance on 'Disclosing Information without Consent'. The possibility of sharing necessary information regarding serious illness and conditions being held centrally should be considered as part of the policy.

69. The evidence of her colleague is that the wing officer was panicked by what was happening that night. Additionally, she appeared uncertain in resuscitation procedures and the response nurse reported that she had to direct her until the second nurse arrived.

    Annual resuscitation updates should be considered for prison custody officers as well as healthcare staff.

70. In interview, the response nurse explained that, when she is asked to attend a cell at night, it might be for anything from someone needing a paracetamol to a 'code blue' emergency. The response nurse questioned why a code blue had not been called in this instance. If it had, then she believed there would have been an immediate direct response from all staff and the cell would have been opened sooner. I recognise there is a new policy now in place at Bronzefield detailing the process for entering a cell at night and commend management for taking prompt action in the aftermath of the events described here.

71. It seems a code blue was not called because the wing officer and the communications room officer were unsure of what to do and unclear about the severity of the situation. I am persuaded that all the staff involved would have behaved very differently on the night if such a code had been called. Similarly, had staff communicated using their radios and not the telephone, this would have greatly aided their understanding of the situation.

72. The wing officer explained why she had used the phone instead of using her radio:

> "I did run back and forth a little bit … to make the phone call to Jo who was in Comms. I know I should have maybe used the radio, but at night state it's on, I think it's on duplex mode so that everyone can hear everyone in case an officer's on a different houseblock walking about, I didn't want it to be speaking that there was something wrong on this houseblock."

73. The wing officer was concerned not to cause panic both amongst other staff and prisoners alike. However, I remain of the view that using the radio system would have relayed important information to other members of staff and probably accelerated the response to the woman's collapse. I accept that the nurse was alerted over the radio and as such the rest of the staff were aware she had been called and was attending. But as a result of using the phone, staff members were not aware of what was happening and indeed what type of situation they were facing.

74. The nurse should have been called at 3:37am when the woman first said she had difficulty breathing. When she later collapsed on the floor, a code blue radio call should have been called. This would have resulted in an immediate response by the orderly officers (Oscars) and the response nurse (Hotel 2). Entry to the cell would have occurred at an earlier stage and the woman could have more quickly received the care she required. The cell should have been entered and rescue breathing in line with the Resuscitation Council UK guidelines should have been initiated at this point. An ambulance should also have been requested.

    The skill mix and training needs of staff, particularly at night, should be reassessed. The Communications Room staff play a vital role when emergency situations occur and should be experienced enough to know how to react to ensure the safety of the prison and all those who live and work there.

75. I am mindful that in another investigation a clinical reviewer has noted the over-reliance on nursing staff in emergency situations. Had a collapse like that which the woman suffered have happened in any of our homes, an ambulance would have been called straightaway. If it were found subsequently that one was not required, it could easily be cancelled. In this case, it appears that the officers left it to the nurse to make a decision about calling an ambulance. The nurse, for her part, seems to have been led by the security implications of the situation and waited quite some time before entering the cell by which time an ambulance was needed urgently.

    Healthcare professionals must be reminded of their duty of care to patients and to work within the codes of conduct of their relevant body.

Clocks and inter-com systems not synchronised

76. The timings in this investigation have been very difficult to establish. I believe this is because, as staff said at interview, each system has it own clock which does not co-ordinate with any other system.

77. The call bell log shows that the woman rang her call bell at 3:36am. However, the CCTV footage shows that no-one attended the cell until 3:46am when the wing officer arrived to check on the woman. The footage then shows the wing officer going back and forth to the woman's cell on five occasions and then returning to the hub. The response nurse arrived and both she and the wing officer checked the woman's cell and returned to the hub on two further occasions. The orderly officers arrived on the wing at 3:57am and, according to the CCTV footage, the woman's cell was finally unlocked at 3:59. This was some 23 minutes after the woman initially rang her cell bell according to the call bell log, and 13 minutes after the CCTV footage shows the wing officer first attended the cell. As already discussed, the Communications Room log also recorded different times.

78. Staff gave different times in their statements about when they were contacted and when they arrived on the wing. Given the disparate sources upon which they were relying, this is not surprising. However, even if the timings on the CCTV are incorrect, it clearly showed staff members going back and forth to the woman's cell and waiting 13 minutes before opening it up. I judge that this was unacceptable.

The following night

79. The night orderly officer made arrangements to cover the wing officer's shift for the next night. However, the wing officer turned up and said she wanted to work. In turn, the night orderly officer said he was happy with this as she seemed fine and able. However, the wing officer was detailed to work on houseblock 3 again that evening, and not on her usual landing.

80. The wing officer believes she was allocated to escort duties the next night, but was in fact again working on houseblock 3. She told my investigator that the woman on the wing were abusive to her during the night, shouting at her that she had killed the woman. When this was put to the night orderly officer, he said that he was not responsible for where people were detailed to work. However, he was mindful of the wing officer that evening and visited her to ensure she was okay, which, he said, she was.

81. I am concerned that more thought was not given to the wing officer's detail the following night. I am aware that the night orderly officer has reviewed his actions in line with this criticism and acknowledges that the situation could have been handled differently. I repeat the recommendation made in paragraph 49 above.

    The director should remind management of their responsibility to care for all staff in the aftermath of a death in custody.

Delivering the news of the woman's death to her family

82. Prison Service Order (PSO) 2710, which came into force in January 2006, provides comprehensive advice about that most delicate and demanding of tasks: delivering the news of a prisoner's death. In the woman's case, I have found that Bronzefield exceeded the requirements. The Director took quick action and the consideration shown for the family was commendable. I judge that the actions in meeting the needs of the woman's family were prompt, sensitive and very well handled.

83. Notices to staff and prisoners were issued promptly with informative updates also being issued without delay. I commend this practice.

CONCLUSIONS

84. The post mortem report concludes that the cause of the woman's death was a myocardial infarction (heart attack) and coronary atheroma.

85. Neither the woman's GP nor consultant was contacted for information on her current condition, upcoming surgery or past medical history. This was despite the fact that she had informed staff that she was awaiting major heart surgery and it having been noted several times that her GP should be contacted. It appears that the seriousness of her medical condition and therefore the care required was not fully appreciated by staff.

86. When the woman became unwell on the night she died, the lack of information available to both nurses and security staff, coupled with the inexperience of the staff on duty in the Communications Room and on houseblock 3, had a major impact on the outcome.

87. The woman had a history of heart problems, her condition was severe and an acute episode could have occurred at any time. However, the clinical review of the woman's care concludes that in several important respects it was less than satisfactory. Additionally, if staff had been aware of the woman's medical history, it seems likely they would have acted differently on the night she died.

    A health needs assessment of the primary, secondary and tertiary care needs of the prisoners at HMP Bronzefield should be undertaken, to include the issues identified by this investigation.

RECOMMENDATIONS

(The recommendations in the list below have been regrouped and do not appear in the same order as in the main text.)

1. **A health needs assessment of the primary, secondary and tertiary care needs of the prisoners at HMP Bronzefield should be undertaken, to include the issues identified by this investigation.**
   Response from UKDS : The HNA has already started and is being led by the Assistant Director for Health Promotion at North Surrey PCT.

Substance Misuse

2. **When prescribing methadone without supporting evidence of a prescription, every attempt must be made to titrate the dose to meet the presenting symptoms of the individual.**
   Response from UKDS : UKDS have recently met with a drug expert to explore a service which links more closely to the Drugs Treatment Service Guide. As a result of this meeting there will be assistance for all UKDS prisons with a review of the current drug service provision and will work in partnership with the UKDS Healthcare Advisor to agree changes to promote a closer working relationship.

Health Screening

3. **When a prisoner presents with any previous medical history or reports that they are receiving prescribed medication, information regarding medical history and current prescribing must be obtained from the GP or hospital.**
   Response from UKDS : It is already the practice of the nurses in the outpatients service to contact the prisoner's GP within 24 hours of arriving at the prison for those for whom this is deemed necessary. A monitoring system is now in place which includes regular chasing of non received information. This is not to say, however, that every set of notes should be obtained. The need for clinical records is a decision that should remain with the lead clinician.

4. **Where a medical history is requested but does not arrive, this must be pursued until the information is obtained.**
   Response from UKDS : A system is now in place for this.

5. **Where there have been previous admissions to prison, the medical record for the past periods in custody must be obtained.**
   Response from UKDS : Archived medical records are now kept with the core records and are retrieved each time a prisoner returns to the prison. The medical in confidence guidelines are still maintained, however this does ensure that previous medical records are available to healthcare staff as soon as possible.

6. **The First Health Reception Screen form must be read carefully by the GP and used as a basis for the meeting with the prisoner. All physical, psychological and drug related health issues declared on the form must be discussed with the prisoner and further clinical information obtained to establish an appropriate management plan, including clinical tests and treatment.**
   Response from UKDS :During the investigation it was confirmed that the GP had read the first health reception screen and had taken the decision to conduct the consultation with the prison in a format to ascertain the current concerns the woman. It is accepted by all that the First health reception screen is a vital source of information and we are confident that all healthcare and medical read the content. As part of the action plan following this report, we will ensure that the lead GP is given a copy of the report and the relevant recommendations highlighted.

7. **For prisoners with a significant past medical history, the information given during the First Health Reception Screen and subsequently to the doctor should form the basis of a nursing plan which is designed to meet the requirements of the patient.**
   Response from UKDS : This is agreed at the First GP appointment following Reception to the prison.

8. **Nurses should be reminded that patients with coronary problems, when presenting with medical symptoms such as swollen legs, itchy skin and angina medication not working, should be referred to a doctor for medical opinion as quickly as possible.**
   Response from UKDS : All healthcare staff will be reminded of the need to monitor prisoners with the described symptoms. This will also be reinforced in the nurses/healthcare assistants training programme.

Records, Record-Keeping and Communication

9. **An audit of record keeping practices at Bronzefield against NMC and GMC standards should be undertaken. It should include the use of contemporaneous nursing records and care plans for the acute period of stabilisation and for a prolonged period where concurrent physical symptoms persist.**
   Response from UKDS: This has already been planned.

10. **In accordance with by the principles set out in the Nursing and Midwifery Council's code of professional conduct, communication between the members of the healthcare team should be encouraged. As part of this, multidisciplinary team meetings and discussions should be considered to improve continuity of care.**
    Response from UKDS: The healthcare department holds weekly care plan meetings. Action can be taken by healthcare staff in the interim periods as required after assessment. This will be audited as part of our clinical governance structure.

11. **Clear, precise and accurate information must be documented in the clinical records including care plans and vital signs observation charts, to ensure that all multidisciplinary team members are aware of the treatment administered.**
Response from UKDS :Detox care plans have been implemented to include the information as described

12. **If a patient refuses prescribed medication, a note should be made in the clinical records regarding the reasons for refusal.**
Response from UKDS :Refusal of medication is entered on to the drug administration sheets and the IMR as appropriate

13. **Baseline clinical observations of temperature, pulse and blood pressure must be undertaken on every new admission requiring clinical substance misuse management for at least the first 72 hours as indicated in PSO 3550. Any abnormalities in temperature or blood pressure recordings should be monitored until stable for a period of several days and the patient reviewed by a doctor.**
Response from UKDS :UKDS have recently met with a drug specalist to explore a service which links more closely to the Drugs Treatment Service Guide. As a result of this meeting the drug specialist will be assisting all UKDS prisons with a review of the current drug service provision and will work in partnership with the UKDS Healthcare Advisor to agree changes to promote a closer working relationship.

14. **The Director must ensure that staff are aware of, and adhering to, the use of emergency "codes". All staff should be advised of the meaning of the codes and in what circumstances to use them. They should be reminded of the proper use of radios and the need to use earpieces where appropriate.**
Response from UKDS : A revised Local Operating Procedure covering entering cells at night has been issued.

15. **A policy on sharing of crucial information should be developed as a matter of urgency in accordance with the Department of Health guidance on 'Disclosing Information without Consent'. The possibility of sharing necessary information regarding serious illness and conditions being held centrally should be considered as part of the policy.**
Response from UKDS : A policy covering medical in confidence issues has been issued and is available to all staff on the prison intranet.

Duty of Care

16. **Healthcare professionals must be reminded of their duty of care to patients and to work within the codes of conduct of their relevant body.**
Response from UKDS : Registered Nursing staff have all documents detailing code of conduct, competency and fitness to practice sent by their regulatory body to their home address, the health care department also hold copies for reference. Roles and responsibilities are also discussed at appraisals.

17. **The director should remind her senior management team of their responsibility to care for all staff in the aftermath of a death in custody.**
Response from UKDS :The Post Incident Care Team now automatically contacts all members of staff involved in any incident. This change to procedure would capture the one member of staff who was missed in this instance.

Continuous Professional Development

18. **The Director must ensure that a clinical policies and procedures manual is available for all staff. Healthcare staff must be reminded to follow agreed policies at all times and should ensure that they remain up-to-date in accordance with the code of professional conduct.**
Response from UKDS: Each member of the healthcare team will be issued with a personal copy of the policies and procedures relating to healthcare, with a copy to be held centrally. Policy reviews will be considered at Clinical Governance meetings with revised policies disseminated for individual update. Training on policies will also form part of the healthcare training programme.

19. **A professional training and development needs analysis must be carried out to identify the training needs of all staff working in healthcare.**
Response from UKDS: This has already been started and will be completed shortly.

20. **Staff on professional registers must be reminded that they have a personal responsibility to maintain their continued professional development.**
Response from UKDS : This will form part of Clinical Supervision and annual reviews

Staffing levels, skill mix and training

21. **The skill mix and training needs of staff, particularly at night, should be reassessed. The Communications Room staff play a vital role when emergency situations occur and should be experienced enough to know how to react to ensure the safety of the prison and all those who live and work there.**
Response from UKDS : This will form part of the action plan emerging from this report.

22. **Annual resuscitation updates should be considered for prison custody officers as well as healthcare staff.**
Response from UKDS : This will be considered as part of the action plan emerging from this report.