Investigation into the circumstances surrounding the death of a woman at HMP & YOI Low Newton in November 2010

Report by the Prisons and Probation Ombudsman for England and Wales

February 2012

This is the report of an investigation into the death of a 30 year old woman at HMP Low Newton in November 2010.

I extend my condolences to the woman's family and friends and all those affected by her loss. I would like to thank her family for their engagement under such difficult circumstances and hope this report provides some answers to their questions. I apologise for the delay in issuing this report and for any additional distress this may have caused.

This investigation was undertaken by one of my senior investigators. NHS County Durham commissioned a clinical review of the woman's care and treatment. The review was carried out by an independent consultant working for Custodial Care Innovative Solutions. I am grateful for his review. I also thank the Governor of Low Newton and his staff for their co-operation.

The woman was remanded into Low Newton in October 2010. She had spent time at that prison on a number of previous occasions and staff knew her well, especially with regard to her long standing history of substance misuse. She was known to abuse substances both in the community and in prison.

Although the woman indicated her intention to address her problems with substance misuse during this final time in Low Newton, there were further instances where it was evident that she was not able to stay off drugs. On the morning of 13 November, she was found lifeless in bed in her cell. When staff examined her, it was clear she had been dead for some time. Toxicological investigation detected the presence of a number of substances, both prescribed and un-prescribed. The prescribed substances were diazepam, mirtazapine, methadone and pregabalin. The un-prescribed substances detected were promethazine, quetiapine, amisulpride and paroxetine. Following post mortem examination and consideration of the toxicology results, the consultant pathologist concluded that the most likely cause of death was fatal opioid toxicity.

In order to ensure that lessons are learned from this tragic death, my report makes three recommendations. Two concern the management and supervision of medicines. The third concerns the handling of potential breaches in security.

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Prisons and Probation Ombudsman **February 2012**

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SUMMARY

1. The woman arrived at HMP Low Newton in October 2010 having been convicted that day on three counts of theft. She was a mother of two and was 30 years old. This was not her first time in prison custody, nor her first time in Low Newton. Most of her offences were driven by her need to fund her longstanding problems with drug and alcohol misuse.

2. On arrival at Low Newton, the woman was prescribed medication for detoxification from alcohol and was also prescribed a methadone replacement programme (to deal with heroin addiction). During the following few weeks there were several instances where she was either found to have taken illicit substances in addition to her prescribed medication, or where she was suspected of attempting to conceal illicit items. This would not seem to have been unusual behaviour for her. Despite this, she also indicated that she wanted to address her problems with substance misuse. One of her motivations for this was a desire to cease returning to prison so she could spend more time with her children.

3. During consultations with clinical and other staff the woman reported a low mood. This was largely related to several stressful events that were occurring in her life but she denied any feelings of wishing to harm herself.

4. On the day before her death, the woman was observed by an officer to be apparently hiding something in the foam of her pillow. A security information report was made and the senior officer was informed but the cell was not searched. That evening she collected her medication as normal. One of the officers involved in supervising the women said that he had no cause for any concern about her. One of her friends said that she was her usual self.

5. On the morning of 13 November, the woman was checked by staff on two occasions. She was in bed and the staff noted nothing untoward. As it was the weekend, and they believed her to be asleep, they did not disturb her. At 9.30am, her friend went to her cell and discovered that she was lifeless. Staff and ambulance paramedics responded and her death was confirmed.

6. Toxicological investigation detected the presence of a number of substances, both prescribed and un-prescribed. The prescribed substances were diazepam, mirtazapine, methadone and pregabalin. The un-prescribed substances detected were promethazine, quetiapine, amisulpride and paroxetine. Following post mortem examination and consideration of the toxicology results, the consultant pathologist concluded that the most likely cause of death was fatal opioid toxicity[1].

[1] Opiate type drugs such as heroin or methadone can cause depressed (slow or shallow) breathing which can potentially lead to unconsciousness and subsequent death through a lack of oxygen reaching the body. Opioids also suppress activity in the brain causing the

7. We make three recommendations. Two concern the management and supervision of medicines. The third concerns the handling of potential breaches in security.

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body to lose its ability to react to the chemical changes (such as harmful levels of carbon dioxide) which would usually trigger the mechanisms responsible for breathing. Depressed breathing can also cause excess fluid in the lungs (pulmonary oedema). This can happen either gradually or else so quickly that this in itself can be a direct cause of death.)

THE INVESTIGATION PROCESS

8. This investigation was opened by one of our senior investigators on 22 November 2010 when he visited HMP Low Newton. He was provided with the prison documentation about the woman and he visited all parts of the prison including the wing where she lived. He met senior prison managers and representatives from the Prison Officers' Association and the Independent Monitoring Board (Each prison in England and Wales is monitored by an independent board of volunteers drawn from the local community to help ensure that standards of decency and care are maintained. Members of the Board have access to every part of the prison and all prisoners held there.)

9. Notices of the investigation were issued to staff and prisoners, inviting those who wished to provide information about the woman to make themselves known to the investigator. He interviewed 12 members of staff and one prisoner. No one came forward in response to the notices.

10. County Durham Primary Care Trust (PCT) were asked to conduct a review of the woman's clinical care while in prison. In keeping with recent common practice in the area, the PCT commissioned a consultancy, Custodial Care Innovative Solutions (CCIS), to carry out the review.

11. The investigator contacted HM Coroner for Durham and Darlington, to inform him of the nature and scope of the investigation and to request a copy of the post mortem report. A copy of this report will be sent to the Coroner to assist his enquiries.

12. One of the Ombudsman's family liaison officers, contacted the woman's family at the beginning of the investigation. She informed them of the investigation and offered them the opportunity to raise any questions or concerns they would like addressed during the investigation. She and the investigator visited the family, during which they raised a number of issues. They questioned the practice of allowing some prisoners to hold some medication in their own possession as this made it easier for prisoners to pass or sell their medication to others. They questioned why the woman was not monitored more closely given that she was known to staff as a person who would try to obtain additional or illicit medication and they asked why she had not been checked for what they believed to be the last 14 hours before her death.

13. The family also raised concerns about events after the woman's death. They did not hear the news until 6.30pm on the day of her death. No-one had been at her mother's home when prison staff visited but they asked why the prison did not check contact details for other family members. The family would also have hoped to speak to the woman's friends when they visited the prison, but they were told that the friends did not feel able to meet them.

14. Following issue of the draft report, the family asked for clarification of several issues, including what the night officer observed at the time of the final roll check on the evening of 12 November. On this matter, the night officer had not been able to recall what the woman had been doing when he checked her. The family also asked that our report incorporate the following personal information:

> "She doted on her children and the family note that she was trying to get help for her illness during this period in custody. She had a great sense of humour and was always making her family laugh. She loved fashion and took great care of her appearance."

15. We apologise for the delay in the issue of this report. Time awaiting the toxicology and post mortem reports contributed to the delay. As did workload pressures.

HMP & YOI LOW NEWTON

16. Low Newton is a female only prison on the outskirts of Durham serving the courts from a catchment area of the Scottish Borders to North Yorkshire and North Cumbria. It is a closed prison and young offender institution holding a small number of young women under the age of 18 years and life sentenced prisoners.

17. The prison has five traditionally built wings, one of which contains dormitory accommodation.

18. Low Newton has a full-time healthcare centre including in-patient facilities. The prison has 24 hour nursing cover and day-time doctors' surgeries from Monday to Friday.

19. Her Majesty's Chief Inspector of Prisons' (HMCIP) most recent inspection of Low Newton was an unannounced short follow-up inspection in April 2009. This was following a full inspection that took place in 2006. (HMCIP conducts unannounced follow-up inspections to assess progress against recommendations made in the previous full inspection. Follow-up inspections are proportionate to risk and short follow-up inspections are conducted where the previous full inspection suggested comparatively fewer concerns.) Following the inspection, HMCIP wrote that:

> "Low Newton … holds a large proportion of women … who are vulnerable, self-harming or mentally ill. Over three-quarters of the women … had a history of problem drug or alcohol use …
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> "This is a difficult and challenging population mix. It is therefore very creditable that Low Newton, which was a high performing prison at the last inspection, had continued to improve in many areas ...
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> "At less than 6% against a target of 9.1%, the mandatory drug testing positive rate was relatively low. However, when the figure included [Subutex], the rate rose to 10.9%. Plans for the implementation of the integrated drug treatment system was due to begin in July 2009."

20. In its report for the period March 2009 to February 2010 the IMB at Low Newton wrote:

> "The Board considers Low Newton an impressive establishment where prisoners receive fair and decent treatment, and the Governor and his managers do everything within their resources to meet demands and challenges arising from working with women prisoners ...

> "The Board recognises the difficulties in preventing drugs … from illegally entering the prison. In addition to the obvious direct impact of drugs, they can be traded and regularly are the cause of assault by prisoners on prisoners ..."

21. There has been only one other death at Low Newton since the Ombudsman's office took responsibility for investigating deaths in custody in April 2004. There are no similarities in relation to this investigation and the previous death.

KEY EVENTS

22. The woman had and an extensive history of crimes of burglary and theft to fund her habit. She had multiple convictions and had been in prison on a number of many previous occasions, including at HMP Low Newton. During these sentences clinical staff and the prison drugs advice service attempted to help her with her substance misuse problems. Despite some attempts to address her substance misuse, the evidence suggests she continued to misuse in prison.

23. The woman's final period in prison custody commenced in October 2010. That day she was convicted at a local Magistrates Court on three counts of theft and was remanded into Low Newton. At this point she was un-sentenced.

24. On arrival the woman saw a nurse for a first reception health screen assessment. The woman reported that her alcohol consumption was 168 units per week (the recommendation for women is that they should consume no more than 14 to 21 units of alcohol per week). She also reported using heroin and diazepam. The nurse noted that the woman was showing signs of withdrawal and referred her to a prison doctor and to the drugs advice service.

25. The doctor on duty noted that the woman had a 15 year history of heroin and alcohol misuse and that she had a community prescription of 60 millilitres (mls) of methadone daily (this was confirmed by the community prescriber). The doctor wrote a prescription for a standard methadone stabilisation plan: starting at 10 mls per day, and rising by increments to 40 mls per day on day four. She also prescribed a seven day course of chlorodiazepoxide for detoxification from alcohol and benzodiazepines. To deal with possible vitamin deficiency common in those with alcohol dependency, The doctor wrote prescriptions for vitamin B supplements.

26. Once all the assessments were completed the woman was moved to the substance misuse unit on A wing. (Prisoners undergoing detoxification or drug maintenance are held on the substance misuse unit for enhanced observation during the stabilisation period.)

27. A Registered Mental Nurse (RMN) told the investigator that he worked in Low Newton's substance misuse unit. He said that in the time he had known the woman he found her to be generally stable in mood. He said she had a lot of friends in Low Newton and tended to interact well with others on the wing. The RMN told the investigator about an occasion during a previous sentence when the woman tried to conceal in her mouth a dose of buprenorphine (a opioid drug similar to heroin). The RMN said that this drug is highly tradable but he did not believe that the woman was a person who generally tried to divert drugs in this way for selling on to others. The RMN also spoke about an entry that he made in the woman's clinical record on 23 October about observing her in her cell smoking a potentially illicit substance. The RMN said that it was the

lunchtime lockup period and when he looked into her cell he saw her using a cigarette lighter to heat a piece of silver foil and inhaling the fumes through a tube. He assumed the substance on the foil was heroin. He tapped on the door and the woman quickly got rid of the paraphernalia and denied she had been doing anything. The RMN saw that the woman was unsteady on her feet and was quite sedated so he spoke with another of the doctors about adjusting the methadone prescription.

28. The doctor to whom the RMN had spoken made an entry in the woman's clinical record around 30 minutes after she had been observed smoking the unknown substance. The doctor noted that the woman was now moving normally and was talking. The doctor recorded that the plan of care was to observe her four times per hour until her cell could be searched. In addition, her methadone prescription would be rewritten. (The adjustment made was that the 15 mls dose of methadone that she was due that afternoon was withheld. In addition, she was required to recommence from the beginning the standard methadone stabilisation plan. Thus, while she had been due to receive two doses of 20 mls of methadone the following day, she received instead two doses of 10 mls.) Her pulse and blood pressure were checked later that afternoon and again in the early evening and were found to be normal.

29. Staff submitted a security information report (SIR) about the incident. (Staff complete SIRs to report concern that a prisoner's behaviour might be in breach of prison security requirements. SIRs help build a picture of a prisoner's patterns of behaviour. An SIR or series of SIRs might lead to further investigations.)

30. The following day the woman said she was not happy with her methadone dose and said she was "rattling" (a slang term used to describe the effects of drug withdrawal). The nurse who made this entry in the records noted that there was no evidence that she was actually suffering any effects of withdrawal. Later that day an entry in her records reported that she had had a settled afternoon and evening. A withdrawal monitoring report was completed over three days from 22 October which recorded no withdrawal symptoms over this period.

31. A CARATS[2]).worker told the investigator that the CARATS team speaks with every prisoner who arrives into Low Newton to ask them if they have any issues surrounding substance misuse and, regardless of the answer, will inform them of the dangers of overdose. This includes the danger of an overdose through mixing drugs and taking drugs that have been prescribed to another person. The CARATS worker said that previously the woman had not wanted to engage with CARATS but when they met on 25 October, she wanted to work with the service to address her drug misuse problems. She gave her reasons for this as wanting to spend

[2] CARATS stands for Counselling Assessment Referral Advice Throughcare Services and is the service that offers help to prisoners with substance misuse problems.

more time with her children, wanting to ease her mother's worries, wanting a better life with better health and wanting to stop returning to prison. During the assessment, the woman was asked about her mental health. She said that she suffered from depression and had not yet dealt with the recent deaths of her father and a brother. She said she thought she would benefit from seeing the mental health team, so the staff from CARATS made a referral to them.

32. On 27 October, the woman had a standard "five day review" of her substance misuse treatment. She was noted to be stable on 40 mls of methadone daily and noted to have opted to be maintained on this amount of medication. She was found fit for discharge from the substance misuse unit and was moved to a regular cell elsewhere on A wing.

33. The woman also saw another of the prison doctors that day (the third doctor). The third doctor's note of the consultation included that the woman was "stressed" due to being back in prison and was also experiencing a "flare up of eczema". The third doctor wrote prescriptions for two creams to deal with the eczema and also prescribed an antidepressant (Mirtazapine).

34. On the afternoon of 28 October, an officer submitted an SIR about the woman and two other prisoners, noting that they were acting suspiciously inside one of the cells immediately following the afternoon medication round. After this incident the woman's telephone calls were monitored for several days. The only conversations she had in this time were with her family and none of these raised any concerns.

35. Also on 28 October, the woman successfully completed her alcohol withdrawal. Starting from the following day, her prescription for chlordiazepoxide was replaced with a reducing diazepam regime (she was to start on 20 milligrams (mg) of diazepam per day, reducing at a rate of 2 mg per week).

36. At a consultation with a doctor on 2 November, the woman requested for sleeping tablets which she said had been prescribed for her the previous week by the third doctor. The doctor noted in the records that there was no evidence of this prescription and he advised the woman to discuss the matter with the third doctor who wrote the prescriptions. An appointment for the woman to see the third doctor was booked later that morning.

37. The woman telephoned her mother on 5 November when she also spoke with one of her sister's and with her daughter. The investigator listened to a recording of this call and noted that she appeared to be in good spirits.

38. Another SIR was submitted about the woman on 7 November. On this occasion, she, and one of the prisoners mentioned in the SIR on 28

October, were noted to be apparently “under the influence”. That evening staff carried out a targeted search of several of the cells. On checking the woman’s cell, staff found a liquid suppository and nine “small white tablets”. Staff were concerned that she might have taken illicit substances so a nurse was called to make an examination. The nurse noted that the woman denied having taken anything and also noted that she appeared to be well, that her speech was normal and she was able to hold a conversation. The nurse advised staff to contact healthcare again if they had any other concerns. No contact was made with healthcare that day.

39. Following the discovery of these illicit substances, staff charged the woman with possession of unauthorised substances contrary to Prison Service rules. (Where a prisoner has apparently contravened Prison Service rules and regulations the circumstances can be considered under the prison “adjudication process”. The evidence is usually considered by a prison Governor and the prisoner is invited to make representations and can ask for legal representation, as the woman chose to do. If the charges are upheld, a punishment will usually be imposed, such as withdrawal of certain privileges for a period of time.) The woman pleaded not guilty to the charge and asked for legal assistance so the case was adjourned. (Her subsequent death meant that the case was never proceeded with.)

40. The woman attended a local Magistrates Court on 8 November further to her conviction the previous month. The court sentenced her to 22 weeks imprisonment.

41. On the following day, the woman was seen by a Community Psychiatric Nurse (CPN) following the referral two weeks before from CARATS to the mental health team. The CPN noted that she was experiencing low mood at times but she realised there were some very specific reasons for this: her father’s death, her use of drugs and medication and her separation from her children. The woman said that she did not think she was benefitting from taking her prescribed Mirtazapine medication but would continue with it. The CPN also described anxiety symptoms, for which she was prescribed Pregabalin.

42. At interview, the CPN told my investigator that 9 November was the first time she had met the woman for a formal consultation. The CPN said that she spoke at great length about her children. She said they were positive factors in her life and she was looking forward to getting out of prison so she could be with them again. The CPN asked the woman about self-harm. She admitted harming herself in the past, but said that she had done so out of frustration and these acts had not been suicide attempts. She said she had no present thoughts of self-harm. The CPN told my investigator that no concerns for her arose during the assessment, although her plan was to review her medication as well as to carry out a more detailed mental health assessment at a later date.

43. Also on 9 November, the woman took part in the last of three CARATS group sessions that she attended over the course of a week. Two of the three sessions focussed on drugs and harm reduction connected with drugs. The other session was on relaxation.

44. On 11 November, the RMN made an entry in the woman's clinical records to say that she asked him that day to start reducing her methadone prescription at a rate of three millilitres per week. The RMN recorded that he actioned this request. Pending a change to the methadone prescription, she was to continue receiving 40 mls of methadone per day.

45. The woman saw the third doctor the following day to ask for sleeping tablets as she had not been sleeping properly in the three weeks she had been back in Low Newton. She mentioned the death of her father in July and that her uncle had been diagnosed with bowel cancer. The third doctor told my investigator that her practice was to only prescribe medication when it was clinically indicated. She decided that she would not prescribe sleeping tablets for her without more evidence that she was not sleeping. To investigate this, plans were put in place to conduct a "sleep watch" on three non-consecutive days commencing on 13 November. (A sleep watch entails random observations at night to determine whether or not a prisoner is sleeping). The third doctor said that she did not object to the plan and instead spoke about two other clinical issues. One was a chest infection, for which the third doctor prescribed Co-amoxiclav (an antibiotic). She also asked for veil cream to mask facial scaring. The third doctor did not prescribe for this condition.

46. On the morning of 12 November, the woman received 40mls of methadone as usual. (The plan to rewrite her prescription chart had not yet been actioned.)

47. A few hours later (at just after midday), an officer submitted an SIR having observed the woman apparently "trying to push something into the foam of her pillow". The officer told my investigator that he noticed the incident while carrying out the lunchtime roll check. He said that he was uncertain what the woman was doing, it was possible that she was simply making her bed. The woman did not notice that he was at her door. After checking other cells, the officer returned to the woman's cell and she was still doing what she had been doing before. The officer said that he was working an early shift that day so went home shortly after submitting the SIR.

48. The woman's cell was not checked that day. Instead a 72 hour target was set for the incident to be investigated. A senior officer was on duty on the wing that day my investigator that at Low Newton many SIRs are completed relating to prisoners acting suspiciously and possibly concealing potential illicit items, such as drugs. She said that a number of factors will determine whether or not a cell search might be carried out

immediately after an SIR is submitted. She said that two members of staff are needed for a cell search so availability of staff to carry out a cell search is one factor. Other factors include other incidents that might be occurring in the prison at the time as well as the certainty on the part of the officer about what he or she might have observed. She did not consider it unreasonable that no cell search was made that afternoon.

49. A senior officer from Low Newton's Security Department confirmed that the factors mentioned by the senior officer from the wing would need to be taken into account when deciding whether or not a cell search should be conducted and the time frames that might apply.

50. The investigator spoke with another of the prisoners at Low Newton. She told the investigator that she had known the woman for many years. She said that the woman was missing her children, but was otherwise fine and had no worries. They had been together the day before her death and she was "her usual self". The other prisoner said that the woman would take other drugs and medications in addition to those that had been prescribed for her. The other prisoner added that this was something "we all do".

51. One of the wing officers (the first officer) told the investigator that he had known the woman for around seven years from her various times at Low Newton. He said that he had a good working relationship with her, always finding her polite and respectful. He considered the woman to be quite a strong character who coped well. He said there were signs that she was beginning to realise that she had responsibilities in the community which meant that she should address her problems with substance misuse.

52. The first officer said that he had seen the woman the evening before her death. He had gone to A wing to assist with control of the evening medication round. (This entails unlocking a small number of prisoners at a time and, once they have received medication, locking them back into their cells before the next group are unlocked.) The first officer said that he unlocked the woman and when she came back to her cell after taking her medication they had a very brief chat. She was her usual self. They said good night to one another and the first officer locked her back into her cell. The time was then around 6.30pm and she, as with the other prisoners, would have remained locked in her cell for the evening and night. After this, she was checked at around 8.30pm during the routine final roll check[3] for the night. An OSG (Operational Support Grade) conducted the check and observed nothing amiss.

53. At a little after 6.40am on the morning of 13 November, an officer carried out a routine morning roll check of the prisoners on A wing. This officer told the investigator that he opened the observation panel of the woman's cell door and, as it was still dark, turned on the night-light inside the cell. She was lying on her right hand side facing the cell wall. She

[3] A roll check entails officers counting prisoners in their cells to ensure all are present.

appeared to be asleep and he closed the observation panel and moved on to the next cell. The officer said that he noticed nothing untoward.

54. At just before 9.00am, staff unlocked the cell doors on A wing. The officer who unlocked the woman's cell told the investigator that her practice if the prisoner is awake is to say "good morning". But at weekends, if the prisoner appears asleep and appears well, she allows them to continue sleeping. The woman seemed to be asleep and as all appeared well she moved on to the next cell.

55. Around 30 minutes later the woman's friend went to her cell so they could go to get their medication together. The friend called to the woman but when she did not answer the friend pulled back the quilt and tried to wake the woman. Realising something was wrong the friend ran out of the cell to shout for help.

56. One of the officers wrote a statement to say that he heard prisoners shouting for assistance at around 9.30am. The prisoners were pointing to the woman's cell. He went into the cell and was joined by colleagues who radioed for emergency healthcare response.

57. The emergency response nurse wrote a statement about her involvement. She noted that she arrived at the woman's cell within a minute of the alarm call. On examining the woman she found no signs of life and also found evidence of rigor mortis (temporary stiffening of the body that occurs some time after death). As a result, resuscitation was not attempted.

Events after the woman's death

58. Two of Low Newton's Family Liaison Officers (FLOs) were asked to visit the woman's family to break the news. They left the prison at just before midday and arrived at her mother's home around 90 minutes later. The officers knocked on the door but received no reply. The officers remained near the house for the next several hours. They asked neighbours about the mother's whereabouts but obtained no useful information. They also telephoned the house a number of times but again without success. The officers had kept in contact with senior staff at Low Newton and in agreement with the governing Governor set off back to Low Newton at 4.15pm.

59. Low Newton then contacted the police to ask them to break the news. When police officers visited the home at around 6.30pm, family members were there and they were informed of the news. One of the woman's sisters telephoned Low Newton and was able to speak with the senior staff member on duty. The following day the prison FLOs returned to the family home to give as much information as they could about the circumstances of the woman's death. The family were offered assistance with the funeral expenses.

60. Low Newton held a hot debrief to consider any immediate issues or possible points of learning that might have been identified from the woman's death. The care team were made available to staff affected by her death and support was also provided to prisoners. Due to the great number of prisoners who wished to pay their respects, Low Newton held two memorial services for the woman.

The cause of the woman's death

61. A post mortem examination was carried out by a consultant pathologist who found no natural disease that would have caused or accelerated the woman's death.

62. Toxicological analysis of urine, blood and stomach contents detected presence of a number of substances, some of which were medicines prescribed to the woman and some un-prescribed. The prescribed substances detected were diazepam, mirtazapine, methadone and pregabalin. The un-prescribed substances detected were promethazine, quetiapine, amisulpride and paroxetine. The paroxetine was only present in the stomach contents indicating it had been ingested not long before death occurred and so could not have caused or contributed to her death. The level of methadone detected was consistent with the range typically found in those who are prescribed that medicine.

63. Having considered the toxicological findings and analysis the consultant pathologist concluded that:

> "A thorough forensic post-mortem together with numerous ancillary tests has failed to demonstrate an anatomical cause of death. The concentration of methadone measured in the post-mortem blood could be consistent with either an acute overdose or therapeutic use. Although the deceased had been prescribed methadone and would have been expected to have gained some tolerance to the effects of this drug, the toxicologist comments that in the absence of a pathological explanation for the cause of death, fatal opioid toxicity could offer a potential cause.
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> "In view of the toxicological opinion and the findings at post-mortem (or lack of them), I am of the opinion that it is more likely than not that the deceased has died as a result of opioid toxicity."

64. During his examination, the consultant pathologist also discovered that the woman had concealed within her body a plastic container holding 11 tablets of various sorts.

65. The investigator spoke with Low Newton's Head of Security, about control of drugs and medication in the prison. The Head of Security said that the results from mandatory drug tests on prisoners in Low Newton showed that the prison was performing very well in controlling illicit drugs. He accepted, however, that testing did not include misuse of

prescribed medication. He explained that some prisoners are allowed to keep some of their medication in their own possession. However, other medications are provided on a daily basis which means some prisoners being issued medication three or four times per day. The medication is issued by a nurse and an officer is present to help supervise the administration. Each prisoner takes her medication in front of the supervising staff and then drinks some water. The prisoner then opens her mouth to show that she has swallowed her medication. The Head of Security said that methadone is given in liquid form and is well controlled. He said, however, that with medication given in tablet form, some prisoners were very skilled in concealing the tablet within their mouths. Some prisoners would then save the tablet to take later on in the day and some would sell or swap the tablet. The Head of Security considered that with the staffing resources the prison had, and considering the number of women receiving medication, the prison was performing very well in controlling misuse of substances.

ISSUES

Clinical care

66. The clinical reviewer, points out in his report that the woman's fundamental health problem was her misuse of alcohol and drugs (both illicit drugs and prescribed medications). At the beginning of this final time in Low Newton she was prescribed chlordiazepoxide for alcohol withdrawal and successfully completed that programme. Once the course ended, the chlordiazepoxide was replaced with diazepam. Another of her prescriptions was for an antidepressant. She was also being prescribed methadone, a medication that she had been receiving in the community. Her methadone prescription followed the standard model: starting at 20 mls per day and stabilising at 40 mls per day. There was an interruption to her plan when she was observed in her cell smoking an illicit substance, believed to be heroin. She was observed closely until the effects of the illicit substance wore off, her next methadone dose was withheld and her methadone plan was rewritten to commence again at the lower dose of 20 mls per day. She was held on the substance misuse unit from 21 October to 27 October for enhanced observation during her medication stabilisation period.

67. The clinical reviewer has commented that the woman's substance misuse treatment was clinically appropriate and that her assessment and care planning on the substance misuse unit was of a particularly high standard. (He has also commented on the timely and effective referrals of her to other services, such as the CARATS substance misuse service, the mental health service and asthma care.)

68. During this last time in custody the woman engaged properly with CARATS services, saying that she was keen to address her problems with substance misuse. Despite this expression of intent she clearly found it difficult to stop misusing substances. She had a past history of taking additional medication or substances and there was evidence that she was continuing to do so during this last time in Low Newton. There was the incident already mentioned when she was observed in her cell smoking a suspicious substance. There was also an occasion when she and another prisoner were observed to be apparently "under the influence" and when a targeted search of her cell was made a number of substances were discovered. Post mortem examination of her stomach contents discovered presence of some un-prescribed substances. In addition, approximately 11 tablets of various and unknown substance were discovered in a plastic container concealed within her body.

69. Toxicological analysis dismissed the possibility that un-prescribed substances had any bearing on the woman's death. Even so, it is concerning that she was able to obtain medicines that had presumably been prescribed to other prisoners. The Head of Security spoke with the investigator about the supervision of medicine distribution queues and the steps taken to check that prisoners have swallowed their medication.

He accepted, however, that some prisoners are very skilled at concealing tablets in their mouths, which they can then take away for selling on to others. This is a serious issue requiring constant vigilance.

The Governor should improve the supervision of medicine distribution rounds to ensure that appropriate checks are always made that prisoners have taken their prescribed medication.

70. The consultant pathologist found that the woman's most likely cause of death was opioid toxicity. It is unclear from the toxicology and post mortem reports whether the concentration of methadone discovered in the blood was consistent with a therapeutic (that is, prescribed) level, or whether she might have taken additional methadone.

71. While the clinical reviewer's report states that most aspects of the woman's care was of a good standard, it also states that there was no real evidence of a particularly well developed or sophisticated clinical risk assessment for the management of medication. By this, he specifies a risk assessment pertaining to the woman in particular, taking account of her known history of concealing and storing medication and linked to medicines management in Low Newton. The clinical reviewer makes the following recommendation, which we endorse:

NHS County Durham and the Governor should commission an audit and review of medicines management arrangements at HMP Low Newton to include:

- **drugs with high potential to be misused/traded**
- **communication between discipline and healthcare staff, including sharing of security information**

The security incident on 12 November

72. At just after midday on 12 November, an officer completed an SIR reporting that he had observed the woman apparently trying to push something into the foam of her pillow. At interview with the investigator the officer was less certain about what he had observed and accepted that the woman might simply have been making her bed. When the SIR was evaluated by the Security Department, a response target of 72 hours was set for the incident to be investigated. One of the senior officers explained that a number of factors will determine whether or not a cell search is made on the same day that such SIRs are submitted. Factors include the availability of staff. She added that many SIRs are submitted about prisoners apparently making attempts to conceal illicit items such as drugs.

73. As no cell search was made that day we do not know whether the woman was attempting to conceal an illicit item. If that is what she was doing, we do not know what the item may have been and nor do we know what happened to it. The prisoner profile at Low Newton inevitably

means many potential breaches of security, along with production of a high volume of SIRs. A great number of such incidents relate to potential misuse of drugs. Various factors need to be considered when deciding whether and how quickly potential security breaches are investigated. However, one of the most significant factors must be the potential that serious consequences might result from the breach. The more prudent response on this occasion would have been for staff to conduct a cell search at the time.

The Governor should ensure that potential security breaches, which potentially impact on the safety of a prisoner, are investigated promptly.

The discovery of the woman's death

74. It was a friend of the woman's who discovered her lifeless in her cell at around 9.30am on 13 November. There had been two cell checks by staff before that. The first of these was the morning roll check, which was made at a little after 6.30am. The other check was at a little before 9.00am when the cells were unlocked. The staff who made these checks both thought that she was asleep and as it was the weekend they left her undisturbed. The staff appear to have complied with what is standard practice for routine checks and cell unlock on a weekend. Nor did they have any reason to believe that she might be in any danger.

75. When the woman's friend called out to staff at 9.30am, they responded without delay. The emergency response nurse arrived within a minute of the alarm call. She tried to move the woman onto her back but found this difficult as rigor mortis had set in. Having examined her, the nurse was confident that the woman had died some time before and that resuscitation should not be attempted. We consider that the nurse's decision was appropriate and in line with the guidance set out in Prison Service Order 2700 that advises that resuscitation should not be attempted where rigor mortis is established.

Family Concerns

76. The woman's family asked a number of questions about practises at Low Newton and about the care she received. They questioned the practice of allowing some prisoners to retain some of their medication in their own possession as this made it easier for drugs to be passed on to others.

77. All prisons operate in-possession policies for medications. One of the main principles driving this practice was that prisoners should be entitled to care equivalent to that available in the community. As a result, prisoners are given a degree of autonomy and responsibility for the storage and administration of their medication. This allows them to take their medication at more appropriate times during the day. Before prisoners are allowed to retain medication in possession, a risk assessment is completed to ensure, as far as is possible, that they will

comply with the conditions of the policy. Controlled medicines such as methadone are not included in the list of medications that can be retained in possession. The woman was not permitted to hold medication in possession. While we understand her family's concern that some prisoners are allowed medication in possession, we do not criticise the policy or the application of it at Low Newton.

78. The woman's family asked why she was not monitored more closely given that she was known to misuse substances and they also asked why she had not been observed for many hours before her death.

79. The evidence would suggest that a reasonable level of checks were made on the woman resulting in her being observed acting suspiciously on more that one occasion, including the time she was observed smoking an illicit substance. This occurred during her first few days in Low Newton and while she was on the substance misuse unit. When she was found to be showing effects of drowsiness, she was then kept under close observation until the effects wore off. Heightened observations of prisoners are usually put in place when a prisoner is identified to be at risk of self-harm. Such monitoring is then removed when the crisis has passed. There was certainly no evidence that the woman had any intention of harming herself deliberately, so heightened observations to guard against that possibility were not indicated.

80. In terms of checks on the woman during her final hours, the final check on the evening of 12 November was the final roll count of the day which would have been made at around 8.30pm. The next check on her was made around ten hours later; at a little after 6.40am on the morning of 13 November. As she was not subject to any special monitoring there was no reason for checks to have been made on her between these two times.

81. The family were also concerned about the time it took for the prison to inform them of the woman's death. Staff from the prison visited her mother's house in the early afternoon on 13 November but found that no–one was at home. The staff asked neighbours about the mother's whereabouts, but were unable to gain information from them. The staff waited outside the home for several hours but eventually returned to the prison. The news was finally broken by the police at about 7.00pm and the family made contact with the prison shortly afterwards. The family questioned why the prison had not made attempts to locate addresses for other family members. She had lived at her mother's home before her arrest and that was where she planned to live after her release from custody. Low Newton had no addresses listed for other family members. While it is unfortunate that it took so long for her family to hear the news of her death, we judge that staff from Low Newton did all that could reasonably have been expected of them in the circumstances.

CONCLUSION

82. The woman had a long history of substance misuse. This included excessive use of alcohol and use of substances such as heroin when in the community. She also had a history of misusing substances when in prison custody when it appears she would use substances in addition to the medications she was being prescribed. She continued this habit during her last time in Low Newton. There is no evidence, however, that she ever intended to harm herself when taking such substances.

83. Although the woman's post-mortem showed that she had taken illicit or un-prescribed substances at some stage close to her point of death, the substances had not been absorbed into her blood stream and so seem not to have contributed to her death. Instead, the consultant pathologist has suggested the most likely cause of death to be opioid toxicity. It is not clear from the toxicological findings whether the concentration of methadone found was consistent solely with the prescribed level or whether she took additional methadone.

RECOMMENDATIONS

The following recommendations were made in the draft report. The Service responses are included in italics following each recommendation:

1. The Governor should improve the supervision of medicine distribution rounds to ensure that appropriate checks are always made that prisoners have taken their prescribed medication.

   Prison Service response: Recommendation accepted. Staff will be reminded of their duty to appropriately supervise prisoners during the distribution of medication. However, very little medication is distributed on rounds at Low Newton. Nearly all medication is issued at treatment dispensing locations where individual checks are made on every prisoner to ensure that it has been taken.

   (The night before her death the woman was issued medication at a treatment location and was supervised when taking it.)

2. NHS County Durham and the Governor should commission an audit and review of medicines management arrangements at HMP Low Newton to include:

   - drugs with high potential to be misused/traded
   - communication between discipline and healthcare staff, including sharing of security information

   Prison Service response: Recommendation accepted. NHS County Durham and the Governor will commission an audit and review of medicines management arrangements at HMP Low Newton. Target date for completion: September 2012.

3. The Governor should ensure that potential security breaches, which potentially impact on the safety of a prisoner, are investigated promptly.

   Prison Service response: Recommendation partially accepted. The prison's duty of care ensures that potential security breaches which may impact on the safety of a prisoner are acted upon promptly and we will ensure that this continues to be the case. However, we believe that this is a very general recommendation relating to action taken, or not taken, on the basis of one SIR.

   (The report states the officer who submitted the SIR should have arranged an immediate search or one at the midday lunch break. This is a question of judgement and the actions taken by staff on this occasion were not unreasonable.)