

**Investigation into the circumstances surrounding the
death of a woman
while in the custody of HMP & YOI East Sutton Park
in December 2010**

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

December 2011

This is the report of an investigation into the circumstances surrounding the death of a woman in December 2010, whilst she was in the custody of HMP & YOI East Sutton Park. She was 52 years old and died at hospital, having been moved there from another hospital. She died as a result of an unexpected cerebral haemorrhage.

I would like to extend my personal condolences to the woman's family and friends for their loss. I apologise for the delay issuing my report and any additional distress this may have caused. I would also like to thank the family for their engagement with my investigation under the most distressing of circumstances.

This investigation was carried out by my colleague. A clinical review, for which I am most grateful, was undertaken by the Clinical Reviewer on behalf of the local Primary Care Trust. I also thank the Governor of HMP & YOI East Sutton Park and his staff, for their help during this investigation.

The woman suffered a ruptured aneurysm in her brain. When she was found, she was cared for appropriately by both staff and fellow prisoners at East Sutton Park. She was then taken to hospital, before being moved to the hospital where she died. I have considered whether the prison could have done anything differently which would have had a positive impact on the outcome for her. I believe that, on the whole, staff acted well.

I make no recommendations as a result of this report. However, I note that the Clinical Reviewer has commented on issues that are outside of my terms of reference (they relate to the medical decisions made after the woman left East Sutton Park) and I urge the health services involved to act upon the recommendations in the Clinical Review.

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

Thea Walton
Acting Deputy Ombudsman

December 2011

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SUMMARY

1. The woman died in December 2010 in hospital. She had been transferred there from another hospital, where she had been taken after she was discovered in a collapsed state at HMP & YOI East Sutton Park. The cause of her death, described in the post mortem report, was due to natural causes as a result of subarachnoid haemorrhage caused by a ruptured brain aneurysm.
2. The woman had no illnesses or symptoms that she had raised as a concern with prison staff preceding her collapse on the evening of 5 December. On the previous day, she had been out shopping as part of her resettlement plans on an unaccompanied town visit. She went with a friend and returned in the evening having had an enjoyable day.
3. The following day she went to work as usual in the kitchens and spent the afternoon and evening quietly in the library. After roll check at approximately 8.00pm, she returned to the room that she shared with three other residents. One of those residents saw her at approximately 8.20pm, lying on her bed fully dressed and snoring loudly. The same resident returned, with another resident, to the room at about 9.00pm. This time they noticed that she had white spittle around her mouth and that she seemed to be having difficulty breathing. They summoned staff assistance and an ambulance was called. They put her into the recovery position and waited until the ambulance arrived. She was taken to hospital where the doctors assessed her and felt she needed more specialist treatment.
4. On the journey to another hospital, the woman's condition deteriorated. Doctors at the hospital tried for some time to save her life, but they were unsuccessful and she died at 3.40 pm.
5. The Clinical Reviewer has identified a number of issues that have resulted in recommendations to NHS organisations. However, they conclude that "because of the size of the haemorrhage identified in the brain scan undertaken at hospital, it was unlikely that the outcome for the patient would have been good".
6. I make no recommendations myself as a result of this investigation, save to endorse those of the clinical review.

THE INVESTIGATION PROCESS

7. This investigation was undertaken by one of my investigators. He first visited East Sutton Park on 10 December 2010 and was given access to the woman's prison records. He saw the unit where she lived during her time at the prison, as well as the kitchen, where she worked.
8. During this initial visit, the investigator met members of the Independent Monitoring Board (IMB), the prison chaplain and the Prison Officers Association (POA). He invited them to provide any information regarding the prison or the circumstances surrounding the woman's death that they thought pertinent. (Each prison has an Independent Monitoring Board. IMB members are unpaid and monitor day-to-day life in the prison to ensure that proper standards of care and decency are maintained. The IMB produces an annual report of its work.) Neither the IMB, the POA, nor any other members of prison staff had any specific matters to bring to my investigator's attention at the time, other than to say how shocked they were at her sudden death.
9. The investigator also spoke with some of the woman's friends and acquaintances from the prison and made notes of those meetings at the time. Following his return to the office, he typed up those notes into a more coherent format.
10. Notices to Staff and Prisoners were displayed at East Sutton Park, particularly in the areas where the woman had lived and worked.
11. The local Primary Care Trust (PCT) was asked to undertake a clinical review of the care that the woman received whilst she was in custody at East Sutton Park. They appointed a Clinical Reviewer to conduct the clinical review. The investigator asked her to consider particularly whether the prison health authorities had acted promptly in identifying the woman's condition and whether there had been any delay in her treatment. He also asked if she could find any evidence contained in the medical record of any underlying condition that ought to have been investigated by healthcare workers at the prison.
12. One of my family liaison officers contacted the woman's family and next of kin to explain the purpose of my investigation and to invite them to ask any questions or raise any issues for consideration. The family raised a number of questions and concerns which I have sought to address on pages 16 – 18. I hope this report addresses their issues fully and helps them better understand the events leading to her death. They will have an opportunity to see and comment on the draft version of my report, should they wish to do so.
13. The investigator contacted Her Majesty's Coroner to inform him of the nature and scope of my investigation and to request a copy of the post mortem report. Upon completion of this investigation, a copy of my report will be sent to the Coroner.

14. After the draft report was published in August 2011, the family liaison officer sent a copy of the report to the woman's family. Having considered the investigation findings, the family reiterated their concerns about the delay in transferring her to outside hospital. They feel the outcome may have been different had she been admitted to hospital more quickly. They explained that several years previously another family member with the same condition underwent emergency brain surgery, following prompt admission to hospital, and has since made a full recovery. The family remain concerned that she did not receive equitable treatment because she was in prison.
15. NOMS also replied to the draft report. They confirmed that they were content with the report.

HMP & YOI EAST SUTTON PARK

16. HMP and YOI East Sutton Park is an open prison for adult women and young female offenders whose main role is the resettlement of women before their release from custody. It was first opened in 1946 as a borstal. It can hold 100 women in 21 dormitory style rooms of varying sizes. Prisoners at East Sutton Park are referred to as residents and I have adopted that term throughout this report.
17. Before arriving at East Sutton Park, all residents are rigorously risk-assessed at their previous establishment for their suitability for an open resettlement prison. This includes assessing the risk they present to the public, the likelihood of them reoffending or absconding as well as the risk they might present to themselves.
18. The regime at East Sutton Park includes provision of farms, gardens, catering and training courses, and physical education. The emphasis is on resettlement and the prison has good community links, with a number of the residents working outside each day. The woman was one of the residents who worked outside the prison for some days each week.
19. From May 2006, East Sutton Park was joined in a “cluster” arrangement with HMP Cookham Wood. In 2007, this arrangement altered so that East Sutton Park became clustered with its neighbouring prison, HMP Blantyre House. Previously, East Sutton Park had been a “standalone” establishment with its own Governor and senior management team. The two clustered establishments now have one Governor. (In July 2007, it was announced that Cookham Wood was to change its function from a women's prison to a male Young Offender Institution (15-18 year olds).)
20. The then HM Chief Inspector of Prisons inspected East Sutton Park in July 2009 and wrote the following assessment:

“Overall, East Sutton Park continues to provide positive support for the women there. It is performing well on two of our tests, and reasonably well on the other two. Resettlement, its core role, needs to reflect and provide for the specific needs of women, especially now that the prison is run alongside a male prison.”
21. She also commented that it was “extremely positive that women were involved in setting and monitoring their own sentence plan targets”.
22. Blantyre House received high praise from the Deputy Chief Inspector of Prisons in November 2010 after an announced inspection showed that the resettlement work being undertaken there with East Sutton Park was amongst the best in the country. (The reason for mentioning this is that both prisons shared a management structure.) He said:

“Blantyre House remains an exceptional, specialist resettlement prison which successfully bridges the enormous gap facing institutionalised,

long-term prisoners who need to be progressively and safely prepared for return to the community in a way likely to equip them to avoid returning to prison in future. To support this function, the prison has created a safe, purposeful and supportive environment, underpinned by positive staff-prisoner relationships and a strong commitment to resettlement. Blantyre remains one of the jewels in the Prison Service crown.”

23. The IMB’s annual report for 2010 highlighted good practice and effective working at the prison:

“The professional and caring attitude of staff towards each of the women in their care has been a key factor in helping to turn lives around and reduce the likelihood of re offending. It is widely discussed and agreed that small prisons are infinitely more effective than large establishments and East Sutton Park is an excellent example of what can be achieved.”

24. East Sutton Park has no in-patient facilities. The healthcare department is staffed by qualified nurses from 8.00am until 4.00pm Monday – Friday. There are out of hours arrangements in place for times outside of this. General Practitioners visit the prison for three half day sessions per week, but are available on call from 8.30am until 5.15pm for telephone advice. Out of hours medical cover is provided by the Primary Care Trust as part of their Out of Hours Contract Services.
25. The woman’s death was the second death to have occurred at East Sutton Park since I began investigating all deaths in custody in April 2004. The first death occurred outside the prison, and I am satisfied that there are no similarities between them.

Lessons from other related investigations

26. In another investigation, conducted into a death in 2007 in which a young man died as a result of a cerebral haemorrhage, the then Ombudsman made extensive reference to loud snoring. In that investigation it emerged that loud snoring can be associated with brain injury and the Ombudsman asked that these facts be highlighted across the prison estate. As a result, information about that investigation was shared in order to heighten awareness of the significance of loud snoring in brain injury. I suggest that Offender Health may wish to share the circumstances of the woman’s death (and that of another prisoner who died in 2008) in due course to highlight again that loud snoring might be a sign of a possible brain injury.

KEY EVENTS

27. The woman arrived at HMP and YOI Holloway on 14 July 2009, having been found guilty at Crown Court of assisting illegal immigrants and making false instruments. She returned to court the following day and was sentenced to five years imprisonment.
28. During her initial health screen at Holloway, the woman told staff that she had no major health problems, that she smoked about eight cigarettes a day, drank socially and did not take drugs. She also said that she had no history of psychiatric problems and that she did not feel depressed. Her only request in health terms was to see the dentist some time and she was put on the waiting list.
29. The woman was transferred to HMP and YOI Morton Hall on 28 July, and her first night screening was very similar to her health checks at Holloway. She had a routine urine sample on 30 July, which showed she had a urine infection, although she had no symptoms or discomfort. She was prescribed antibiotics for this. In addition to being put on the dentist's waiting list, she was also asked if she would like to receive immunisation for Hepatitis B to which she said yes.
30. On 30 July, the woman told the nurse that she had a pain in her neck and that she would like to see the doctor about that. When the doctor saw her on 4 August he wrote in her medical notes that she had been having pain in her neck for the past month and told him she had tingling in her fingers and right arm. He examined her and decided that she needed to be seen by a physiotherapist.
31. The physiotherapist saw the woman on 18 August. He manipulated her shoulder and discovered that she had tight muscles in her shoulder and needed to do some regular exercises. He said that he would see her in three weeks. He saw her on 8 September for further treatment but she failed to keep her next appointment on 22 September and he did not see her again.
32. The woman asked to have a routine smear test on 26 August, but it does not appear that this was done whilst she was at Morton Hall. She did however have her Hepatitis injections on 10 September, 21 September and 27 October. She also had a tooth extracted on 23 November. The last time that she was seen by health services at Morton Hall was on 13 May 2010 for a rash to the face, for which she was given cream to apply for six weeks.
33. The woman was moved from Morton Hall to East Sutton Park on 27 July 2010. She was held overnight at HMP Bronzefield and met two other prisoners there who were also on their way to East Sutton Park. They established a friendship from that point and once at East Sutton Park they maintained that friendship, eventually moving into the same dormitory.
34. The woman underwent initial health screening procedures at East Sutton Park and had no medical complaints. The results of a cervical smear on 9 August

were normal. Aside from this entry in her medical records, the only other entries concern missed dental appointments.

35. On Saturday 4 December, the woman went out shopping as part of her Resettlement Day Release (RDR) programme. She had previously been on RDR and also overnight stays (Resettlement Overnight Release – ROR) with her family (the last one being to her sister's house on the weekend prior to her death). On this particular RDR she was accompanied by Resident A at East Sutton Park.
36. The resident told my investigator that they had both travelled to Maidstone and had been window shopping most of the day. The woman offered to buy her a small token gift, but she declined her offer. The woman bought a mug which was the subject of a shared joke between them. The resident described events which sounded entirely normal for two people out shopping for the day. She told my investigator that at no time did the woman complain of any illness, nor did she appear to have any discomfort or health problems during their shopping trip.
37. The following day, Sunday 5 December, some of the residents my investigator spoke with remember seeing the woman at various times throughout the day. Nothing specific stands out in their memories, but they are all certain that nothing was causing her any concern – especially not any health problems. The resident, for example, recalled her being in the library in the early evening and said that she appeared her usual self. She said that the woman would often sit in the quiet of the library because she was quite a shy person who enjoyed her own company (although she also had a close circle of friends). She remembered her leaving the library at about 8.00 pm.
38. Resident B remembered that she and the woman worked in the kitchen together that morning and said she thought she spent much of the afternoon in the library. Both she and another resident recalled that after roll check at approximately 8.00 pm, the woman went back to her room. Resident C said that she made a telephone call to her mother and returned to the room after the call at approximately 8.20 pm. She saw her lying on her bed, snoring loudly. She was propped up on the bed and appeared to be asleep. The resident collected the pen that she had gone to the room for and returned to the dining room to resume a game she had been playing with some of her fellow residents, including Resident B.
39. At approximately 9.00 pm, both residents returned to their room and immediately realised that something was wrong with the woman. She was still in the same position Resident C had left her some 30 minutes earlier, but she appeared to have been incontinent and she had white foam around her mouth. She was still breathing, very loudly, and was unresponsive when the two friends tried to communicate with her. They immediately went to the centre office and summoned staff assistance.
40. Upon returning to the room (which is only a short distance from the centre office), Officer Support Grade (OSG) A and an officer put the woman into the

recovery position with the assistance of both residents, ensuring that her airway was clear. The officer then left and called for an ambulance. The call to the ambulance service was recorded at approximately 9.19pm. The third member of staff on duty that evening was OSG B. He was charged with looking after the office in the first instance and later going to the gate area to assist the ambulance crew when they arrived.

41. The woman's friends and the two members of staff kept trying to rouse her whilst they waited for the ambulance, but she managed only a vague arm movement towards the back of her head. She appeared to be semi-conscious and was completely uncommunicative throughout this time.
42. The ambulance arrived at approximately 9.45pm and the paramedics immediately thought that the woman had suffered an epileptic fit or a stroke, or might have had a brain haemorrhage. Their initial assessment of her showed that her blood pressure was 162/93 (which is high), her pulse was 52 (which is a little slow), her pupils were of slightly different sizes but were reacting to light and that her level of consciousness on the Glasgow Coma Scale was recorded as 11. (The Glasgow Coma Scale (GCS) is a tool used by health professionals to assess levels of consciousness. The range of scores is between three and 15, with three being totally comatose and 15 being fully alert.)
43. The ambulance crew, assisted by prison staff, secured the woman into a carry chair and transferred her to the ambulance. They initially thought they would take her to the local hospital, but it transpired they took her to another hospital as it specialises in treating people who have had a stroke.
44. The ambulance left the prison at 10.12pm en route for the hospital. At 10.22pm, the ambulance crew informed the hospital that the woman's condition had deteriorated with her GCS dropping to three. They arrived at hospital at 10.47pm, where she was assessed and started on an intravenous fluid, with observations being made every 15 minutes. She showed some small sign of improvement with her GCS rising to five at first and later to nine.
45. At 11.00pm, the woman was anaesthetised and intubated (a tube inserted into her airway) and she was started on artificial ventilation. Her GCS dropped to three again, but this was expected as she was induced into a coma by drugs (The GCS was therefore no longer a good measure of her condition.)
46. Meanwhile, the officer tried to contact the woman's mother and sisters to advise them of what had happened, but failed to get any response when she first tried. Later, the hospital was able to get a hold of her family to tell them that she was in hospital.
47. The woman was taken for a CT scan at 11.45 pm which showed that she had suffered a large intracranial bleed (bleeding within the skull) and there was some indication that there was pressure building up inside her head that would cause irreparable damage if it was not treated by surgery. (A CT scan is a computerised tomography scan which is a highly sophisticated type of X-

ray that shows, via a computer, images from within the body including soft tissue (normal X-rays showing hard substances such as bone).)

48. Within the clinical records, there is then some confusion about exact timings, but in terms of event occurrences, the clinical reviewer has been able to ascertain the following:
 - a. There was communication between two hospitals.
 - b. Consultants agreed that it would be best for the woman's chances of recovery, that she should be transferred to the other hospital.
 - c. Transport and staff were arranged by the first hospital for the transfer.
 - d. The ambulance arrived at the other hospital at 4.45am on 6 December.

49. The woman had another CT scan at 5.35am and this time the results showed that damage to her brain 'was not compatible with life'. Unfortunately, despite efforts by doctors at both hospitals, she died in the afternoon with her family beside her.

ISSUES

Clinical Issues

50. The Clinical Review is a comprehensive report of the clinical issues investigated by the local PCT. It needs to be read as a stand alone report on all matters relating to the clinical care the woman received whilst she was in prison, and the care she received after she left East Sutton Park. I have to concentrate on the care she received whilst under the care of the prison authorities, but the Clinical Review includes findings outside of my area of responsibility. The salient issues for me fall into three main areas namely medical care received by her up to the time of her collapse; the care she received from her collapse until she left the prison by ambulance and the care she received after her transfer to hospital. I have full jurisdiction over the first two areas, but only partial jurisdiction over the last.
51. Aside from the usual healthcare assessments that all prisoners undergo when they first enter a prison, the woman appears to have only attended healthcare departments on about four other occasions. One of these was for a routine cervical smear test, one for a dental appointment, one was for treatment of a urine infection and the other occasion was for treatment of a rash on her face. On some of these attendances, routine blood pressure readings were taken, but there was no other treatment identified, save for the conditions mentioned above. She was regarded as a fit young woman with no medical problems.
52. The clinical review has a separate section dealing specifically with the issue of headaches. In that section, it is made clear that this is an area of concern to the family, and one that rightfully requires close scrutiny given the cause of the woman's death. The clinical reviewer notes that there is no evidence of her having attended the healthcare department complaining of headaches. It is equally clear that she certainly had suffered some pain from headaches on more than one occasion (on her last home visit and on the night of 5 December at least), although there is no evidence to suggest that any healthcare professional was aware of her headaches.
53. Given that many people do suffer headaches and self-medicate with paracetamol, the prison allows each suitably assessed prisoner to have in their possession eight paracetamol for emergencies such as headaches occurring during the night. The woman's records do not show that she had ever asked for her initial allocation of paracetamol to be replenished. It would be unsafe to assume that this meant she had not acquired more paracetamol either whilst out on town visits or from her friends, had she run out of her initial supply, but I do believe that she was highly sensible and if persistent headaches had been causing her problems, I feel confident she would have sought help from healthcare services.
54. The clinical review goes on to describe in good detail what a subarachnoid haemorrhage is, some of the signs and symptoms and the risk factors associated with people who have suffered subarachnoid haemorrhage. It is evident from the report that although the woman was a smoker, she was not a

heavy drinker, nor was she recognised as someone who had poorly controlled high blood pressure. Although headache can be a sign of such a haemorrhage, it is more typically described as a 'thunderclap headache' and this does not fit the description of the headache that she seems to have retired to her bed with on the evening of 5 December – at least not initially.

55. Equally, none of the other symptoms associated with subarachnoid haemorrhage appear to have been present prior to the woman's discovery at 9.10pm. She showed no signs of a stiff neck, sickness and vomiting, slurred speech, changes in personality, behaviour or mental confusion. I can only conclude from this that there were no early warning signs of her impending sudden and catastrophic haemorrhage either in the weeks before 5 December or even the hours before her final collapse.
56. The second timeframe that requires closer scrutiny is the actions that were taken once the woman was discovered at 9.10 pm. Resident C told my investigator that she had gone to her room to fetch a pen at about 8.20pm on 5 December and had seen her to be asleep. She left the room and returned with Resident B at approximately 9.10pm. They found her in a state of collapse and raised the alarm. Staff arrived very promptly and an ambulance was contacted, records show, at 9.18pm.
57. It seems from interviews and statements that the officer might have contacted the duty Governor before telephoning for an ambulance. This would have added a few minutes to the overall response time if this is correct. It would have been more appropriate for the ambulance to have been called first, but in this instance I do not think it would have altered the course of events significantly.
58. Two members of staff stayed with the woman, as did both residents, to give support and comfort to the woman whilst they waited for an ambulance. There was not much more pro-active first aid treatment that could have been given that would have made her chances of survival any better, until paramedics arrived.
59. The ambulance service were not informed that the woman's condition was life threatening and as a consequence they sent out a category B ambulance which should have been on site within 19 minutes. Ambulance control had been told by staff at the prison that the casualty was a female who was breathing, but not completely alert, who had a headache and was foaming at the mouth. This was a description that was accurate and was indicative of someone who has had a fit and was now on their way round from that fit.
60. When the ambulance crew arrived at the bedside of the woman at 9.44pm and assessed her condition, they found someone with slightly raised blood pressure, with a slower than normal pulse who was fairly alert in that her GCS (Glasgow Coma Scale) was 11/15. They formed the initial impression that she appeared to be "post-ictal" (having had a recent fit). They made arrangements to transfer her to hospital and gave her some oxygen.

61. The ambulance left the prison at 10.13pm – approximately one hour after the woman had first been discovered as being unwell. Just prior to her leaving the prison, the ambulance crew had re-assessed her GCS and assessed that still to be 11/15. En route to hospital, her condition deteriorated and when she arrived at hospital at 10.46pm, her GCS was 3/15. Her pupils were not reacting to light and she was totally comatose, indicating that she had suffered a severe brain ‘injury’ (injury as in the medical term used to describe this sort of event).
62. From the prisons perspective, I do not believe anything further could have been done to safeguard the woman than they actually did. Indeed, I believe that the actions that were taken, in the unfortunate circumstances they and she found themselves in, were acceptable. The one action that might have been done differently, and would otherwise have led me to describe it as exemplary, was that the governor was telephoned before the ambulance. But, as I say, I do not believe this had a significantly negative impact on the outcome of these events.
63. I believe also that the woman being comforted by people she knew, was a re-assuring thing for her, despite her poorly condition. In many prisons, this type of comfort and re-assurance would not have been permissible as staff usually like to clear everyone away from incidents involving other prisoners (I accept that this is an understandable reaction). In this instance it shows great trust and compassion which I believe should be reflected in this report.
64. The communication between prison staff and ambulance control which resulted in a category B ambulance being dispatched is, I feel, a communication issue at the ambulance service end. I believe that the officer would have been guided into which answers to give via the ambulance services emergency call algorithm – something she had little or no control over. (An algorithm is an aid to decision making, following a set process of asking questions and following guidelines based on the answers to those questions. Health services across the country use them to help clinicians make decisions about the best treatments to offer patients, subject to the information they are given.) These algorithms are tried and tested throughout the NHS system and are usually fairly robust. In this instance, the officer, who is not a medical expert, effectively was like any member of the public reporting finding someone collapsed and requiring emergency services help.
65. The ambulance services decision to send a category B ambulance was not helped by the fact that the ambulance had to come from Rochester. This also added to delays in treating the woman. It is difficult to say whether the combined delays of finding her, summoning the ambulance, the ambulance arriving and the dispatch of the ambulance to a hospital, would have significantly impacted on her chances of survival. It might be reasonable to suggest that anyone of them in themselves was unlikely to have made any difference, but the cumulative effect cannot have helped. However, the clinical review medical expert makes it clear that the size of the haemorrhage suffered by her was significantly large and that her chances of survival from the outset were not good.

66. The journey to hospital was where the woman showed the most significant deterioration (aside from her original collapse). A CT scan at the hospital showed that she had suffered a large intracerebral bleed and that this was causing severe pressure to build up within her skull. Notwithstanding this, doctors still thought there was a chance of survival if she underwent an operation. They therefore made arrangements to transfer her to another hospital.
67. There are matters relating to the transfer that I believe warrant further scrutiny, but I am sorry to say these matters are outside my remit. They might be more properly explored at the Coroner's Inquest.

Family Issues

68. The woman's family raised a number of issues with my family liaison officer. They visited the prison shortly after her death to attend a memorial service there. They said they were grateful for the kindness shown towards them by prison staff and residents. They wanted to know if she had any previous medical problems, particularly relating to frequent headaches she used to get, that might have been a warning of her condition.
69. My investigation has led me to conclude that there is no evidence of the woman having any recognised medical condition that might have reasonably been identified by health services at any of the prisons she had been in, as being cause for concern. The clinical review confirms that, by and large, she had no medical problems that either she or health services would have suspected were serious enough to warrant investigation. It seems that the regular headaches that the family were aware of did not cause her enough concern to bring them to the attention of medical staff. It appears that she would manage those headaches herself, either by taking simple pain relief or by resting. The family told the family liaison officer that she had visited them the weekend before her death and, one night, she had taken herself off to bed with a headache and a pain in her leg. The next morning she awoke with no complaints – and she did not report any such incident to the health team at East Sutton Park.
70. The family also wished to know if the woman had been prescribed paracetamol as some was found amongst her possessions. The only evidence of legitimate prescribing for paracetamol I have found is in the fact that every 'suitable' prisoner at East Sutton Park is given a 'welcome pack' that contains paracetamol. She would have been one such 'suitable' prisoner. She may also have purchased paracetamol legitimately on one of her shopping trips, or else they may have been given to her by another resident, which is not strictly speaking legitimate. The fact of the matter is that in open prisons, access to many things is easier than in closed prisons and therefore is harder to control. It is also not entirely desirable that everything is controlled in open prisons in the manner in which they are in closed prisons. Women in open prisons are encouraged to take responsibility for their own actions and behaviour so long as they behave responsibly. There is nothing

to indicate that she was anything other than a very sensible woman and it is therefore no surprise that she might have had a few paracetamol in her possession.

71. The family told the family liaison officer that they were aware the woman had previously been admitted to hospital. I can find no evidence for this and wonder if this might relate to her shoulder problems when she was seen by a visiting physiotherapist whilst at Morton Hall.
72. Every person who comes into prison is supposed to have their previous medical history thoroughly explored. This should include contacting the individual's own GP to ask for either a summary of their medical history, or else copies of salient parts of their medical records. In the woman's case this was not done when she first arrived into custody at Holloway. The Chief Inspector of Prisons sets out expectations for prisons, among which is the standard that prisons will seek peoples previous medical history and contact a person's GP. Notwithstanding that omission on the part of Holloway, it is pertinent to note that she was an intelligent individual who was competent to communicate any health concerns she might have had when she arrived into prison, and she had no such concerns at her initial health screening on 14 July 2009. Furthermore, she had no significant medical concerns at the time of her subsequent health screenings at Morton Hall and East Sutton Park. It is unlikely that if the prison had been in possession of her previous medical notes, anything significant would have been brought to light from them.
73. In respect of the emergency response to the woman's sudden illness on 5 December, the family made the point that no emergency doctor was called, it took healthcare staff some time to arrive at the scene and more than 30 minutes passed before the ambulance arrived. I have investigated each of these aspects of emergency treatment and have discovered that no healthcare staff arrived because nursing staff at East Sutton Park are only in attendance at the prison on a part-time basis. In common with most prisons that do not have in-patient facilities, nursing staff are only on duty within the prison during core hours. At East Sutton Park, there is no nurse on duty at a weekend. In a similar vein, no doctor is present within the prison and the on-call arrangements are such that in an emergency, prison staff are expected to summon an ambulance, rather than call out a doctor. The staff on duty at 9 pm on a Sunday evening did exactly what they should have done by calling for an ambulance.
74. The length of time it took the ambulance to arrive at East Sutton Park is a matter for the local ambulance service, but there is nothing in any records I have examined to suggest there was any delay in the paramedics gaining access to the woman once they arrived at the prison. The officer sent OSG B to the entrance to the prison to meet the ambulance and had raised the barrier before it arrived. The ambulance left the prison approximately 30 minutes after it arrived.
75. The small degree of treatment the people around the woman were able to offer before the ambulance arrived is in keeping with basic life support and

first aid principles. They ensured she was able to breathe, tried to reassure her and stayed with her until paramedics arrived. The only additional care a trained healthcare worker might have been able to offer would have been the introduction of oxygen via a mask – but the clinical reviewer does not say this would have made any significant difference to the outcome for her.

76. The family believe there was a delay in the ambulance departing because the staff on duty that evening could not provide any medical history for her. It is correct that the hospital telephoned the prison after she had arrived there, asking for detailed medical information such as the medication that she might be on. The staff present did not have access to that medical in confidence information and were unable to help hospital staff. The officer even tried contacting healthcare staff at home in order to obtain access to some information, but was unable to do so.
77. Ambulance services across the country face this dilemma constantly, in both residential settings as well as domestic settings. They do not allow the absence of accurate and up to date medical information to stand in the way of them doing their job. In the same way, in the woman's circumstances, the health services coped with not having access to her medical files – and in any event, they would not have revealed anything of significance to them.
78. The family received some of the woman's property (her clothing) directly from the hospital. Amongst those items were her jeans, tights and underclothes and those items were 'soaking wet'. They asked for an explanation about this. I am aware that she was incontinent and so are the family. They feel, however that her clothing was wet beyond what would have been expected from normal incontinence. I am sorry to say I have no further explanation for this. Prison staff have told me that they would not have returned her property to the family in this condition, but they had no control over the matter.
79. The family were also unhappy about the return of the woman's property, amongst which was listed a bible. It is understood that this bible was of great importance to her, as she used it regularly and had made hand written notes within. It was listed as having been collected from her room and put into a sealed bag ready for return to the family. When the family opened the bag sometime after the memorial service, there was no bible there. Enquiries have been made by the prison into this matter but they have not been able to account for the loss of the bible. I am sorry to say I can provide no explanation on the matter.

CONCLUSION

80. The circumstances surrounding the death of the woman are tragic. She was a relatively young woman who was fit without any significant indicators of risk. She suffered a sudden, critical collapse, without any prior warning or indication that she had an aneurysm within her skull. This aneurysm burst at a moment when other people were not immediately around. When she was found by friends, they summoned help and by and large, emergency services were called for without undue delay. Despite taking a little longer than would have been desirable, paramedics took her to hospital. She was still breathing and was somewhat conscious when they left the prison on the night of 5 December.
81. On route to the hospital, the woman's condition deteriorated even further, but despite this, following a CT scan and further assessment by doctors at the hospital, it was thought possible that an operation might save her life. Doctors arranged for her transfer to another hospital for surgery. When she arrived there, a further CT scan showed her condition to be more serious than initially indicated by doctors at the previous hospital. Her condition was determined to be 'not compatible with life'.
82. After her family had arrived, it was agreed with all parties that the ventilator system that was assisting the woman to breathe should be switched off. She was pronounced dead at 2.05 pm.