The death in custody of

a woman at

HMP Holloway in March 2005

Report by the Prisons and Probation Ombudsman for England and Wales

June 2007

This is the report of an investigation into the circumstances surrounding the death of a woman in March 2005 at HMP Holloway.

The woman had been assessed by a doctor during her reception into Holloway in February 2005 and had commenced a methadone detoxification programme the same day. When a post mortem failed to ascertain her cause of death the Coroner appointed a clinical pharmacologist to offer his opinion based upon the post mortem findings, the toxicology report and other investigations. The conclusion was that the woman died as a result of cumulative toxicity caused by her prescribed methadone. I extend my sincere condolences to her family for their loss.

This investigation was carried out by two of my colleagues. A clinical review of the woman's clinical care and treatment was carried out by Islington Primary Care Trust (PCT). In addition, a nurse consultant in substance misuse, carried out a review of the management of the woman's detoxification programme. A Suicide and Self-Injury Prevention Consultant to the Prison Service Women's Team conducted a review of the woman's F2052SH documentation. I am very grateful for all three of these additional reviews.

I would also like to thank the Governor of Holloway and his staff for their help during this investigation.

The first draft of this report was competed in September 2005. At that time, I was instructed by the Metropolitan Police to delay its dissemination while the Crown Prosecution Service (CPS) considered whether to bring a prosecution against Holloway or any of its staff. In December 2006, I was informed that the CPS had announced a preliminary decision that, as the evidence stood, there would be no criminal proceedings. I very much regret that the woman's family have had such a long wait.

The investigation has revealed a number of serious concerns about the care and treatment afforded to the woman both while a patient in Holloway's detoxification unit and on her transfer to standard location. In particular, she was prescribed a methadone detoxification programme when it was likely that she had little or no heroin addiction and little previous experience of opiates or opioids.

I make six recommendations of my own. More detailed recommendations will be found in the additional reviews.

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

Stephen Shaw CBE **June 2007**
Prisons and Probation Ombudsman

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SUMMARY

The woman had a long history of alcohol misuse which had resulted in homelessness and behavioural problems. She also had a history of acts of deliberate self-harm.

In early November 2004, the woman was remanded into Holloway after allegations that she had breached a restraining order. The woman saw a doctor the following day. She said that she was dependent on alcohol and crack cocaine. After verifying this with a urine test, the doctor prescribed chlordiazepoxide and diazepam for detoxification. The woman returned to court in mid November and was given bail.

In early December, the woman was remanded back into Holloway accused of a number of further alcohol and drug related offences. The woman was only prescribed chlordiazepoxide for alcohol detoxification on this occasion. She remained in Holloway for the next three months until she was discharged in mid February 2005.

The woman was briefly back in Holloway several days later. She was again prescribed chlordiazepoxide.

Having been released from Holloway, the woman was rearrested at the end of February for a further breach of a restraining order. After spending two nights in police custody, she was taken to Holloway. When the woman saw the doctor, she not only reported alcohol and crack cocaine dependence but also said she was dependent on opiates, saying that she had been taking heroin for the previous two months. A urine sample proved positive for the substances that the woman had declared. In addition to being prescribed chlordiazepoxide and diazepam, the woman was also prescribed methadone for detoxification from heroin. As had happened during previous periods in custody, the woman was assessed to be at risk of self-harm or suicide and an F2052SH form was opened to provide appropriate monitoring and support. The woman was placed into Holloway's detoxification unit.

The woman remained in the detoxification until her transfer to standard location in early March 2005. During interviews with my investigators, there were differing views given by officers and nurses working in the detoxification unit about the woman's condition. Some of the officers thought the woman seemed drowsy at times, and two of them said they spoke to nurses about this. In contrast, the nurses did not think there was anything out of the ordinary about the woman's condition. The one exception was one morning in early March when a nurse observed the woman to be drowsy while she was waiting to receive her next methadone dose at 8.25am. The methadone was appropriately withheld and given later that morning instead.

Although there was disagreement between officers and nurses about the woman's condition, all staff said that they were surprised she had been prescribed methadone. They all knew her to be someone who used alcohol but not heroin. However, nothing was mentioned to any of the doctors at the prison.

Trying to reach an independent and objective conclusion on the extent, if any, of the woman's drowsiness during her detoxification was not helped by the fact that clinical observations were not taken or recorded by the nursing team. (The term 'clinical observations' refers to a patient's vital signs such as pulse, blood pressure and

temperature.) Prison Service Orders require that clinical observations be taken for at least the first 72 hours when stabilising patients undergoing detoxification. My investigators were told that Holloway had ceased the routine taking of clinical observations some time before the woman arrived in the prison. Pressure of work was one of the reasons given. This is not acceptable and one of my recommendations addresses this matter.

When the woman was transferred to ordinary location in early March, there were further indications that she was not coping well with her detoxification programme. Two of the officers in the unit said the woman seemed drowsier than most women going through detoxification. This view was echoed by two of the prisoners who shared a dormitory with the woman. Another prisoner, who was located in a different dormitory, thought the woman was drowsy as she queued for her night-time medication at 7.30pm that evening. This prisoner challenged the officer supervising the medication queue. She asked him why, in view of her condition, the woman was going to be given even more medication. The officer thought that the woman seemed okay. Nor did the nurses think that there was anything untoward about the woman's condition. During that night, two of the women in her dormitory noticed she was coughing and snoring loudly. The night officer (an Officer Support Grade) also noticed that she was breathing heavily.

At about 8.30am the next day, one of the other women in the dormitory tried to wake the woman, realised she was dead and alerted staff. When the woman was examined, the indications were that she had been dead for some hours.

A clinical pharmacologist was appointed by the Coroner to provide an expert opinion on the woman's cause of death. The clinical pharmacologist concluded that the level of methadone given to the woman was suitable for a person who was used to taking opioid type drugs, but would have been too high for a naïve user. He found that the methadone accumulated to a toxic concentration in the woman's body and ultimately caused her death.

All of the evidence indicates that, although the woman was heavily dependent on alcohol, she did not normally use heroin. The urine test at the end of February indicated that she had used heroin during the five days since her last release from Holloway. However, her claim that she was heroin dependent, and had been using the drug for the previous two months, does not accord with the fact that she had been a prisoner in Holloway for most of the previous three months. The various clinical reviews are consistent in their opinion that the woman should have been questioned in more detail about her claims before being prescribed methadone detoxification. Concerns are also raised by the reviewers about the decision to prescribe diazepam.

My investigation also found some deficiencies in the woman's care as a prisoner who had been judged to be at risk of self-harm.

The specialist reviews make over 60 recommendations in total, some of which will already have been addressed by Holloway. The vast majority of the recommendations relate to clinical care and treatment of those undergoing a detoxification programme. The remaining recommendations relate to the care and management of prisoners judged to be at risk of suicide or self-harm.

INVESTIGATION PROCESS

The investigation was opened shortly after the woman's death when my investigators, visited Holloway and were given access to the woman's records. Notices were issued about the investigation and displayed around the prison. These invited any staff or prisoners who felt they had relevant information to make themselves known to the investigation team. One prisoner came forward in response to the notices.

My investigators spoke with representatives of the Prison Officers Association (POA) and the Independent Monitoring Board (IMB) for their views on the prison in general and the woman's death in particular. Formal interviews were conducted with staff and a number of prisoners.

One of my investigators, accompanied by one of my Family Liaison Officers, met the woman's parents and one of her brothers. The woman's family were concerned that she had been assessed at Holloway as having a drug dependency and put on a methadone detoxification programme. They said that, during her previous times in custody, the woman had not been put on methadone. Furthermore, in the brief period that the woman was out of prison in between her final two periods in custody there was not enough time for her to have developed a dependency on heroin. They said that her problem had always been alcohol not drugs.

The woman's mother visited her daughter on the Friday before her death and found her to be very drowsy, thirsty and hot. The woman told her mother that this was due to the side effects of methadone and she would only be on this medication for a few more days. The woman's mother said that she spoke with her daughter on the telephone at around 6.30pm in early March. The woman's mother could not recall being concerned about her daughter's condition at the time, but when she subsequently listened to a recording of the conversation she thought that her daughter did not sound herself. She had been coughing a lot and was 'not fully with it'. The woman had also written a letter that evening which was very erratic. The woman's mother felt that staff should have noticed that her daughter was in a 'drugged' state. The woman's family were also concerned that the position of her bed on the night she died prevented her from being properly observed by staff.

The woman's family described her as physically very strong. They were concerned that she may have taken illicit drugs in the prison and it was this that caused her death.

Three additional reviews have been carried out to assist this investigation. Islington Primary Care Trust, which is responsible for the delivery of health care at Holloway, has carried out a clinical review of the woman's care and treatment. A nurse consultant in Substance Misuse from the Department of Health has carried out a review of the management of the woman's detoxification programme. A Suicide and Self-Injury Prevention Consultant, at that time employed by the Prison Service Women's Unit, carried out a review of the woman's self-harm prevention documentation. This investigation has also taken account of the views of the clinical pharmacologist appointed by the Coroner to review information arising from the woman's post mortem and the toxicology reports to offer an expert opinion on the woman's cause of death.

HMP HOLLOWAY

Holloway is a women's local prison located in North London serving courts throughout the South East of England. It accommodates just under 500 prisoners.

Holloway is a prison with many diverse functions. Its main role is to hold women on remand or awaiting sentence. It also has a Mother and Baby Unit and a Young Offender unit that holds girls and young women aged between 15 and 21 years old. Holloway has a significant number of foreign national prisoners.

The majority of women arriving at Holloway suffer from alcohol and/or drug problems that require detoxification. Many of the women also have mental health needs.

Holloway has a very transient population with only one in four still at the prison six weeks after their initial reception. In 2003/04, Holloway accepted 6,500 new prisoners.

The woman's death was the third at Holloway since April 2004 when I took over responsibility for the investigation of deaths in prison custody.

Holloway's Detoxification Unit (H1)

Holloway established the first ever prison detoxification provision in 1997 with almost 1,400 women being admitted for treatment in the first year. This figure rose steadily, reaching a peak of almost 2,500 in 2003, before falling to 1,850 in 2004. Almost 14,000 women were safely and successfully treated at Holloway over this eight year period. In 2004, 8,592 women across England were safely and effectively managed in local prisons using similar protocols and practice to that which had been founded and developed at Holloway.

Over 60 per cent of all new prisoners received into Holloway require clinical detoxification from opiates, alcohol and benzodiazepines. Prisoners receive health screening on arrival and those requiring detoxification are admitted to the detoxification unit (H1). The screening process includes separate assessments by a nurse and a doctor on the day of arrival, with questions asked about drug and alcohol usage. Urine testing is also carried out. Holloway once used a semi-quantative urine testing system which gave a result showing precise levels of the drugs tested for. Semi-quantative urine testing was subsequently replaced with a 'dip and read' test that only gives a positive or negative result rather than a result showing levels of drugs in the urine. The original semi-quantative urine testing machine became obsolete in 2001. An alternative machine was obtained, but it proved inaccurate and was less safe than the standard 'dip and read' tests. 'Dip and read' testing is used across the male and female prison estate. Prison Health is investigating available machinery for semi-quantative testing.

For alcohol detoxification, Holloway uses chlordiazepoxide (Librium) usually for a period of seven days. For opiate detoxification, methadone was used up to the end of July 2005 when it was replaced by Subutex as the standard choice. The methadone detoxification programme, which is what the woman received, commenced at a low dose of 10 milligrams (mg) twice daily, increasing to 30mg by day four, before steadily reducing from day six and continuing on for 19 days. The standard methadone detoxification programme was originally completed in ten days, but it was later extended

to 14 days. Finally, it was extended to a 19 day programme including a five day stabilisation period for all opiate users in preparation for the new integrated drugs treatment system (IDTS) standard (published by the Department of Health in 2006).

Current Prison Service Orders require that clinical observations of pulse and blood pressure should be undertaken for a minimum of the first 72 hours following admission into a detoxification unit. In addition, the procedure at Holloway required staff to monitor women at the time of medication rounds and for the detoxification programme to be adjusted or revised if appropriate. Adjustments to the programme included postponing a dose of methadone if the woman was observed to be too sedated at the time it was being dispensed. In such a case, a urine test would also be carried out and referral made to a doctor if considered appropriate. In some cases, adjustments could be made to an individual's overall detoxification programme.

Originally, women would remain in H1 for a period of around five to seven days before moving to the post detoxification unit (D1) when assessed to be well enough. In D1, prisoners would be in the less intensive phase of detoxification and would begin to participate in the general activities and regime of the prison. Women would be transferred from D1 to ordinary location when considered medically fit to move, following assessment by a doctor or senior nurse. In the summer of 2004, D1 was closed for a number of reasons, including the need for refurbishment. D1 was re-opened in April 2005.

Historically, prisoners' medical records at Holloway were paper based. In July 2004, some paper based medical records were replaced by electronic records (the EMIS system). Certain paper based templates, such as the First Reception Health Screen, were set-up in EMIS in electronic form. Other templates, such as clinical observation charts and care plans, remained paper based.

KEY EVENTS

The woman's entry into Holloway

In early February 2005, the woman was arrested and taken into police custody. She reported taking heroin and cannabis the day before and having taken alcohol that day. The woman was given diazepam and Temazepam (sedative drugs to control agitation caused by alcohol withdrawal and to assist sleeping). At Edmonton Crown Court she was sentenced to six months imprisonment and taken into custody at Holloway. Immediately prior to this, the woman had been in Holloway continuously from early December 2004 to mid February 2005, and had also been there for four days later on in February.

The senior nurse was on duty in reception at Holloway on the afternoon of the woman's arrival. The senior nurse said that nurses on reception do not usually see Prisoner Escort Records (PER forms – used when a prisoner is passed from one agency to another and which indicate if the prisoner might be at risk), nor do they usually see any other paperwork. The senior nurse did not know the woman from her previous times in Holloway but the woman looked vulnerable so, as the senior nurse on duty, she made a point of choosing to conduct her preliminary healthcare screen (part of the standard reception for new prisoners). This was around 4.00pm. The senior nurse recorded the woman's pulse as 90 beats per minute and blood pressure as 160/105 (indicating high blood pressure). The woman reported that she been in prison the week before and was back again having been sentenced to six months imprisonment for breaching an injunction. The woman reported that she was withdrawing from both drugs and alcohol. The senior nurse assessed the woman as displaying fairly severe symptoms of drug withdrawal.

The senior nurse was very worried by the woman's comments about feeling suicidal so had opened an F2052SH. The senior nurse then took the woman to see the reception doctor and also contacted the detoxification unit (H1) to let them know that the woman would be arriving there.

The reception doctor saw the woman at just after 5.00pm. The doctor knew the woman from her previous times in Holloway. The woman reported that she had an alcohol and opiate dependency. As the doctor was speaking with the woman, he entered information into her computerised medical records held on the EMIS computer system. This system contains a template with questions to be asked and tick boxes to be completed when interviewing those declaring a drug dependency. The doctor did not explore with the woman the extent of her opiate usage – the amount of spend and frequency of use – he told my investigators that this would be explored the following day by the detoxification doctor. At Holloway, chlordiazepoxide (Librium) is used for alcohol detoxification and, at the time, methadone was usually used for opiate detoxification. The doctor was aware that the woman had not reported having a drug dependency on the previous occasions she had been in Holloway. However, methadone would not be given solely on a prisoner's word that she was a user of opiates, it would be given only with a positive urine test. In the woman's case, her urine test confirmed the presence of opiates so the doctor wrote a prescription of methadone and she was given 10mg that evening. In addition, the doctor prescribed chlordiazepoxide for alcohol detoxification,

diazepam for benzodiazepine dependence, two inhalers for asthma and thiamine hydrochloride (a vitamin supplement).

The woman was located in the detoxification unit (H1) and allocated to dormitory 23.

The following day, the woman was seen by the detoxification doctor. As a matter of routine, all prisoners with drug or alcohol dependency are seen on the morning following admission by a doctor for a review of their medical history and history of drug or alcohol use. The detoxification doctor said that she knew the woman from previous times in Holloway, although she did not know her very well. On previous occasions, the woman had only declared dependency on alcohol and crack cocaine but this time she also said she had been using heroin. This was confirmed when her urine test proved positive for opiates, as well as for other drugs including amphetamines and crack cocaine. The detoxification doctor asked the woman repeatedly about her claim to have been using heroin, but the woman insisted. The detoxification doctor asked the woman how she took heroin and the woman replied that she smoked it. The woman had been a bit evasive, but because of her history of self-harm, the detoxification doctor did not want to provoke her and felt it was better to give her medication rather than to withhold it.

My investigators asked the detoxification doctor about the record she made of the woman saying that she had been using heroin for the previous two months given that she had, in fact, been in Holloway for most of that time. The detoxification doctor said there was no guarantee that the woman had not been using heroin while in Holloway, but in any case the protocol at Holloway is that if a person declares they are a heroin user and their urine test proves positive for opiates, methadone is prescribed.

The detoxification doctor acknowledged that the woman was on a lot of medication, but she said that many women in Holloway are multi-drug users with complex needs. It is therefore often necessary to prescribe a lot of medication for them, which they are able to tolerate.

At interview, a number of nursing staff who knew the woman said they were surprised about her being on methadone. They knew her as someone who would go through alcohol detoxification, but not as a user of heroin. The nurses consistently said that there was nothing about the woman's condition during her time in H1 that was out of the ordinary or which gave them any cause for concern.

One nurse told my investigators that the nurses spoke about the woman being on methadone this time, however her urine sample had proved positive for opiates. It was therefore a case of following normal practice. The nurse said that when women are receiving methadone, clinical observations of pulse and blood pressure should be carried out. She acknowledged that the taking of clinical observations had ceased some time before the woman's last period in Holloway due to a number of factors including pressure of work and staffing problems. For the same reasons, Holloway had also stopped issuing self-assessment questionnaires (a form for prisoners to complete with details of their drug and alcohol use) and also ceased completing withdrawal monitoring charts (on which a woman's withdrawal symptoms would be recorded and scored).

A discipline officer in H1 remembered the woman from her various times in Holloway. He said that the woman was no different to many of the women going through

detoxification at Holloway: typically they would not be very well for several days and would then get well and move on to standard location. The officer made an entry in the woman's F2052SH form in early March that she was drowsy, but as far as he could recall he thought he had made that note not long after she had had her medication.

When the woman attended for her morning methadone two days later, she was judged to be drowsy by the dispensing nurse. The woman's urine was tested, but proved positive only for her prescribed medication. The woman's methadone, which had been due at 8.30am, was withheld and not given until later that morning. The nurse said that a note should have been made about this both in the unit's urine record book and in the woman's EMIS computer record, but in neither was a note made. Apart from that morning, there was no other occasion when the nurse observed the woman to be drowsy.

The woman was visited that day by the Community Mental Health Team. The mental health worker told my investigator that the woman was a lot drowsier than she had ever seen her before. However, the woman had been able to engage in conversation. The mental health worker was not concerned about the woman seeming quite drowsy. She assumed that staff would have recognised if she was drowsier than could be expected for a person going through detoxification.

The following day, the woman's heroin detoxification programme peaked with her receiving a single dose of 30mg of methadone. On that day different discipline officers made two separate entries in the woman's F2052SH about her appearing drowsy. In the morning an entry referred to the woman being 'very groggy' and in the evening an entry was made that she 'looks very tired.'

The next morning another entry (by a third officer) was made in the woman's F2052SH that she 'seemed very drowsy'. Later that day, the woman was moved to dormitory 28. This was apparently due to the other women in dormitory 23 complaining that her snoring was disturbing them. The woman again had a single dose of 30mg of methadone. The woman's methadone doses began decreasing from the next day starting with a dose of 25mg.

A discipline officer in H1 said that she had met the woman a number of times on different occasions when she was in Holloway. The officer described the woman as a pleasant person who never caused problems. Like the nursing staff, the discipline staff were also surprised at the woman being prescribed methadone. When questioned by one of the discipline staff, the woman said that she had been dabbling in a bit of heroin. The officer said at interview that her concern at that remark was that 'dabbling' in drugs is not the same as having a drugs 'habit'. The officer made three separate entries in the woman's F2052SH form about her being drowsy. The officer said she had never seen the woman in that condition during the previous occasions she had been in Holloway. The officer mentioned this to nursing staff and was aware of the occasion when the woman's medication was withheld.

Another officer told my investigators that she knew the woman quite well and that she felt they had quite a good rapport. The officer said that when the woman came into Holloway on this last occasion, she was different to how she had been previously. On this occasion the woman was drowsy and also disorientated at times. The officer made

entries in the woman's F2052SH about this. However, the officer did not think that the woman was markedly different to the other women going through detoxification, although there was one occasion when she spoke to a nurse about her. The officer was not certain of the occasion, but thought it might have been in early March when she recorded in the F2052SH that the woman had asked her to go to the off-licence for her. It had not seemed to the officer that the woman was joking when she made that remark.

The day before the woman's death

At 8.30am on the day before the woman's death an officer made an entry in the woman's F2052SH that she 'looked very drowsy'. At 10.30am, another officer made a note: 'Has been on exercise, seems in good spirits. No concerns.' However, at 12.20pm the officer noted in the woman's F2052SH that she was 'still very drowsy'. At interview, the officer said that as the woman was still drowsy on the day before her death – her final day in H1 before transfer to standard location – she spoke to another officer about whether she was fit to relocate. They concluded that 'on paper' the woman was fit to go and the decision, in any case, was one for the clinical staff to make. The officer made an entry in the woman's records: 'No problems on detox.'

The nurse who authorised the woman's move to standard location said that any of the qualified nurses in H1 is able to authorise transfers to standard location. The nurse had known the woman for a couple of years and had spoken with her earlier in the week when she discovered that the woman was receiving methadone. The woman told the nurse that the last time she had been at liberty she had been using drugs as well as alcohol. The nurse said that the woman had been slightly drowsy earlier in the week – a symptom of withdrawal – but there had been nothing about this to cause concern and then she had settled. The nurse saw the woman just before she left H1 and there had been nothing about her to give cause for concern. At 2.24pm, the nurse made an entry in the woman's EMIS medical record: 'Fit for ordinary level from detox unit. Transferred to B4 this pm.'

A senior nurse saw the woman on the morning of the day before her death. She said the woman was fine that day. She had packed her bag for the move to B4 and seemed happy to go to normal location.

At some time after 2.00pm that day the woman, along with three others from H1, were taken to normal location – two were going to A4 and two, one of whom was the woman, were going to B4. The escorting officer said he spoke to all four of the women and his view was that the woman seemed no different to the others and there was nothing to indicate any problems. The officer said that, on escorting the women, he carried their paperwork while they carried their own bags. The officer first went to B4 where he passed the woman plus one other to the receiving officer. The escorting officer said that the practice was to inform the receiving officer when women were subject to F2052SH monitoring. But when he mentioned that the woman was subject to such monitoring, he realised that he did not have the relevant documents. The escorting officer took the two remaining women to A4 and, on returning to H1, collected the woman's F2052SH, which had been with the doctor, and took it to B4. The escorting officer estimated that about 10 to 15 minutes elapsed between dropping off the woman in B4 and his return there to deliver her F2052SH.

When a prisoner subject to F2052SH monitoring is discharged from the healthcare centre to standard location, a discharge report should be completed. At 3.00pm, the doctor completed the woman's discharge report. In a section titled 'Summary of in-patient stay', the doctor wrote: 'Already located in [ordinary location]'. At interview, the doctor said that before signing a discharge report of a prisoner he does not know, he will first see her to ensure she is fit to be in standard location. However, as he knew the woman, he would only have checked with staff that she was well that day.

The receiving officer said that he received the woman and one other prisoner into B4 on the afternoon of the day before the woman's death. The woman was not totally focussed, but he said that is usual for women going through detoxification. The receiving officer located the woman, along with the other prisoner, into dormitory 20. At the time, the receiving officer was unaware that the woman was subject to a special watch as her F2052SH form did not arrive until later on in the afternoon. When the F2052SH did arrive, the receiving officer did not consider whether the woman should have been asked to change beds. The bed that the woman occupied abutted the wall of the dormitory toilet which meant that only the bottom of the bed was visible from the observation hatch.

Another officer told the investigators that she was in fact the receiving office and the woman's records contain an entry by this officer to support this: 'Rec'd onto B4 placed into dorm 20, on [methadone].' This officer said that women going through detoxification are typically disorientated and unsteady on their feet. However, the woman was unusually unsteady and drowsy and, when taken to dormitory 20, she stumbled into the room. The other woman transferred in from H1 was located into the same dormitory.

My investigators spoke with three of the prisoners who shared dormitory 20 with the woman. All three described the woman as very drowsy, and two of them described her as being more drowsy than usual for someone going through detoxification. One of the prisoners knew the woman from previous times in Holloway. She described the woman as wobbly and said that she could barely stay awake.

The senior nurse, who had carried out the woman's first reception health screen on arrival at Holloway works on the level 4 houseblock in addition to working in reception. The senior nurse was involved in the methadone administration round at 4.00pm on the day the woman arrived on B4. As methadone is a controlled drug, it is issued separately to other medication. When the woman reached the medication hatch she was looking behind her talking to the other women in the queue. This caused her to sign her methadone chart in the wrong place. The senior nurse told the woman off for doing this. The senior nurse told the investigators that the woman had been well at that time. Had the senior nurse been concerned, she would have withheld the woman's methadone.

The officer who supervised the methadone queue at 4.00pm thought that the woman was fine at that time. The officer next saw her at around 5.30pm when the rooms were unlocked for prisoners to collect their evening meal. The officer asked the woman whether she wanted to eat, but she said she did not. She also said that she was fine.

At about 6.30pm, the woman went to the wing office to collect a PIN number to allow her to make a free telephone call, and also to ask for a visiting order for her parents. Two officers were in the office and they spent some time with the woman. One of the officers

again described the woman as typical of those going through detoxification: 'not 100% with it and was slurring a few words, but she was okay.' The other officer said that communicating with the woman was very difficult. She had great difficulty in understanding what was being said to her, and it was also difficult to understand what she was saying in reply. The officer thought that the woman was drowsier than usual for a person going through detoxification.

At around 7.15pm to 7.30pm, the final medication round of the day takes place. This is when all other prescribed medication, apart from methadone, is issued. The prisoner who had been immediately behind the woman in the medication queue, asked to speak to the investigators. The prisoner said that she knew the woman from previous times in custody. She knew the woman used alcohol, but not drugs. The woman was very drowsy that evening. The prisoner had never seen her like that before and she was also unlike any of the other women going through detoxification. The prisoner did not think that the woman should be given any more medication that evening, and she mentioned this both to the woman and to the officer supervising the medication queue.

The officer said that, when supervising a medication queue, his practice was to make small talk with the women in the queue. He spoke with the woman and she seemed okay other than that her hands were slightly shaky, which is a common symptom in people going through detoxification. The officer said that he did notice that the woman was issued with a large number of tablets and he recalled the other prisoner remarking upon that. The officer said that he thought his reply was that it was a matter for the doctors and nurses.

The dispensing nurse at the evening medication round said that when the woman reached the medication hatch she asked if she was okay and the woman replied that she was. There was nothing about the woman's appearance to give the nurse any cause for concern. Had she been concerned, the nurse would have withheld her medication and would have referred her to the doctor.

The senior nurse who had given the woman her methadone at 4.00pm saw the woman again at some point that evening – possibly around 7.30pm. The woman approached her to apologise for signing the methadone chart in the wrong place. Again, there was nothing about the woman to give the senior nurse any cause for concern.

A Senior Officer (SO) on duty on level 4 that day saw the woman on association at some time between 6.00pm and 8.00pm. The woman seemed well, allowing for the fact that she was going through detoxification. The SO had not known then which bed the woman occupied in dormitory 20, although she discovered this the following day. She accepted that the woman's bed could not be easily observed from the observation hatch. The SO added that she was unaware of bed choice for prisoners subject to F2052SH monitoring previously being a factor for consideration.

One of the prisoners from the dormitory said the last thing the woman did that evening was to start writing a letter to her parents. However, she was falling asleep as she was doing so. Another of the women said that after the woman fell asleep she began to make a lot of noise in her sleep. She was snoring and coughing. The prisoner said that she woke the woman at some time around 11.00pm because of the noise she was making. The woman seemed okay and asked for a cigarette.

The woman's death

An operational support grade (OSG) on duty in B4 and C4 on the night of the day before the woman's death said that, upon starting a shift, she checks the women subject to F2052SH monitoring. It was not ideal that the woman was in the bed next to the toilet, but the OSG said that she could see the woman from her shoulders downwards. If she had thought it necessary to do so, she would have asked her manager to have the woman swap beds with one of the other women. Through the night, the OSG made hourly entries in the woman's F2052SH that she appeared to be sleeping. Once the lights in the dormitories had been switched off, the OSG used a torch to check the women subject to F2052SH monitoring. At about 3am, the OSG noticed that the woman was breathing very heavily, but neither at that time, nor at any other time in the night, did she have any concern about the woman's well-being.

At night time, the F2052SH process requires the night officer to satisfy him/herself that the prisoner is well, although prisoners are not woken at these checks. However, at the final check before handing over to the day staff, the night officer is required to obtain a response from all of the prisoners. Similarly, the oncoming day staff should also carry out a roll call in confirmation that they have taken responsibility for the correct number of prisoners, all of whom are well. In conducting her final check that morning the OSG made an entry at 7.15am in the woman's F2052SH: 'Called and responded.' When asked about this entry, the OSG said that she had obtained a response from some of the women in the dormitory and was told by them that the woman was asleep.

An officer who was due to work a day shift in A4 arrived early for her 7.30am start. As she walked through B4 and C4, she counted the prisoners in those wings. Night staff are not able to go home until the day staff have carried out their own counts. By counting the prisoners in B4 and C4, the officer allowed the night officer to go home and also saved a job for the oncoming day staff in those wings. After counting the prisoners in B4, the officer recorded the figures in the wing diary. The officer admitted at interview that, although she counted the prisoners, she did not obtain responses from them all. She said that most of the women would usually be asleep at that time so it was unusual to obtain responses from them all. She acknowledged that she should have obtained responses from the prisoners on open F2052SHs.

At 7.30am, another officer made an entry in the woman's F2052SH: 'Answered to check by day staff.' The officer said that he had not personally checked the woman at that time. He made this entry after being told that another officer had completed a check of all the prisoners. The officer added that F2052SH monitoring was often a team task, with the officer carrying out a check then passing information to another officer who might be the one to make the entries in the F2052SHs.

The residential nurse for the level 4 houseblock began dispensing the morning medication. When she went to dormitory 20 she was told that the woman was still sleeping so she proceeded down the corridor.

Another of the prisoners in the dormitory tried to wake the woman so she could have her medication. The prisoner realised that the woman was dead and alerted the staff by banging on the dormitory door.

An officer responded to the noise and was told by one of the prisoners that the woman was blue in colour. Two officers went into the dormitory and checked the woman while radioing for a Code Blue alert to be issued (a Code Blue alert is a warning of a life threatening incident needing an immediate response from clinical and other staff). An officer checked the woman for a pulse, but found no signs of one. Nor did she have signs of breathing. The officer said that he was checking the woman's mouth for blockages in her airway when the first response nurse arrived and called for the blue bag (a medical bag containing emergency resuscitation equipment, including oxygen, and which is kept in the nurses' room on each level).

The first response nurse said that she arrived in B4 in less than a minute from the Code Blue alert. She said that when she went into dormitory 20 she saw the woman, but there were no staff by her bed. The first response nurse said that the woman was purple in colour. The woman had no pulse and she was not breathing. At that point, a second nurse arrived as did other staff. The first response nurse was carrying a 'response bag' with basic emergency equipment, but she also asked for the blue bag as that contains more equipment. The first response and an SO started attempts at resuscitating the woman. A defibrillator was brought to the dormitory, but when it was used it ordered that no shock should be given. Staff continued with their efforts to try to resuscitate the woman until ambulance paramedics arrived when they took over. However, all attempts at trying to resuscitate the woman proved unsuccessful and she was pronounced dead at 8.52am.

The residential nurse said that she was returning to the B4 nurses' room when an officer called out to her that she was needed. Before being able to help, she first had to secure her drugs trolley in the nurses' room. She said she went to dormitory 20 and began to check the woman for signs of breathing and a pulse. When the first response nurse arrived, the residential nurse went back to the nurses' room to collect the blue bag. Due to lack of space in the nurses' room, the blue bag hangs from a mounting fairly high up on the wall. The bag was too heavy for the residential nurse to take down from its mounting, but an officer came to the room to do this for her. The residential nurse then returned to dormitory 20 with the blue bag. By then, sufficient clinical staff were already present to give aid to the woman so the residential nurse's involvement was only to pass over equipment from the blue bag. The residential nurse confirmed that there is no defibrillator on level 4. Both levels 3 and 5 have defibrillators, so level 4 will collect one of those if needed, as happened in the woman's case.

A Principal Officer (PO) was the duty Orderly Officer on the day of the woman's death. The PO explained at interview that the Orderly Officer's role is to ensure that the prison regime is operating appropriately and to take control of incidents. The PO responded to the Code Blue alert and, on arriving in B4, found clinical and other staff on scene attempting to resuscitate the woman. The PO contacted the communications room to check that the ambulance service had been contacted and was told that was the case. The PO detailed officers to keep a log of events and to prevent unauthorised entry into dormitory 20. During the debrief held later that morning, one of the two ambulance crews which had responded to the 999 call reported being held up for a few minutes while waiting to be escorted to A4. The PO said that the process that should be followed is for the gate-house to be informed that an ambulance has been called, and a member of staff deployed as escorting officer. The PO was uncertain about what

happened with the ambulance in the woman's case. What he thought might have happened was that, while the escorting officer was locking the security gate after the ambulance had passed through, the ambulance may have continued on without waiting for the escorting officer and perhaps got lost.

After the woman's death

The woman's parents live in North London. Holloway's family liaison officer, accompanied by a chaplain, visited the family later on in the morning of the woman's death to break the news in person. The prison offered to pay funeral expenses and representatives from Holloway subsequently attended the woman's funeral.

The family took up an offer to visit Holloway and they saw the dormitory where the woman died. The family considered that the overall contact with Holloway had been very good. They especially mentioned the family liaison officer.

The family's only complaint was that it had not been possible to see the woman's body on the day of her death. They understood that this was due to a delay with the police's assessment of the scene rather than the fault of the prison.

ISSUES

Cause of death

Following the woman's death, post mortem and toxicology examinations were carried out. Her family wondered whether she might have taken illicit drugs in the prison and whether this had caused her death. However, the toxicology result showed drug concentrations in keeping with the levels of the woman's prescribed medication. Hair analysis indicated that she had not been a habitual user of opiates. The post mortem examination found that the woman's major organs were healthy and unremarkable and the pathologist stated that her cause of death was unascertainable.

In a further effort to determine the cause of death, the Coroner asked for the expert opinion of a clinical pharmacologist. The clinical pharmacologist assessed the risks associated with each of the drugs that the woman had been prescribed and those associated with combining all of them. Finally, the clinical pharmacologist considered whether the woman's death could have been caused by combining the various medicines, and in particular whether the level of methadone in her body would have been sufficient to cause death. The clinical pharmacologist wrote that there is little risk of a metabolic interaction between the drugs taken by the woman, although he also said that the combined action of chlordiazepoxide and diazepam will be additive and both may deepen any sedation and mental confusion caused by methadone (and vice versa). The clinical pharmacologist went on to say that the analysis of the woman's hair indicated that she had not taken methadone or other opioid drugs regularly in the last six months of her life. The levels of methadone given to the woman when she came back to Holloway the last time were suitable for a person who was used to taking methadone, but were too high for a naïve user of the drug. As a result, the prescribed methadone accumulated to a toxic concentration in the woman's body and ultimately caused her death.

In due course, the woman's cause of death will be determined at her inquest.

Management issues surrounding H1

At their initial visit to Holloway, my investigators reviewed the woman's records and spoke informally with staff in H1 to gain an understanding about how the detoxification unit operates. Having spoken with several members of staff, my investigators then spoke with the head of healthcare, about some of their immediate concerns. For instance, staff had said that for the previous year or so clinical observations had not been undertaken of prisoners going through detoxification, nor were care plans being written. The head of healthcare was unaware of these omissions. My investigators did not interview the head of healthcare formally as he was suspended from work soon after the investigators' preliminary visit to Holloway.

Holloway's deputy Governor, promoted to that post in January 2004, told my investigators that in March 2002 she was Holloway's Head of Residence. In that role, she was in charge of the entire residential function of the prison – including the healthcare and detoxification units. However, even upon her promotion to deputy Governor grade, she was still a lower grade than the head of healthcare. The deputy Governor believed that the head of healthcare took up post around the middle of 2002

and always reported directly to Holloway's governing Governor. In the summer of July 2004, Holloway appointed a new governing Governor.

The deputy Governor said that it was not long after the head of healthcare took up post that it became apparent that there were difficulties in his working relationship with Holloway's lead clinician in detoxification. The deputy Governor said that the lead clinician in detoxification told her that unsafe practices were developing in the delivery of detoxification services, in particular that staff were not following protocols. The lead clinician in detoxification had mentioned her concerns to the head of healthcare, but he refused to accept that there were any problems. The deputy Governor herself began to feel concern about practices in healthcare and she spoke about them when briefing the new governing Governor on his appointment. The deputy Governor said that, when the Prisons and Probation Ombudsman issued his reports into the deaths in 2004 of two women at Holloway, the prison drew up action plans to deal with the Ombudsman's recommendations. The action plans were then submitted to the relevant unit managers for them to take forward. The deputy Governor had been led to believe that the action plans relating to healthcare were being taken forward.

The healthcare practice manager was appointed in January 2005. He is a non-clinician, so his responsibilities were for the non-clinical functions of healthcare, such as the unit's budget, its IT systems, its administration team, and personnel issues. The healthcare practice manager said he very soon began to have concerns about various aspects of the healthcare unit, such as staff training and development, performance management of staff, staff working relationships and control of the budget. When the head of healthcare was suspended from work in April 2005, the healthcare practice manager was asked to fill the post of acting head of healthcare. After taking on his new role, the healthcare practice manager oversaw a thorough review of the processes and systems in healthcare. This has resulted in many changes such as investment in staff training, staff recruitment, and the introduction of new protocols and procedures for patient care. Building work and refurbishment has also been undertaken, including the development of a first night centre. The healthcare practice manager thought that staff morale has improved and that the healthcare unit is now a safer environment for its patients.

The substance misuse adviser told my investigators that he has many years' nursing experience and in recent years had become closely involved in substance misuse services, including setting up such a service at Wormwood Scrubs. In the Easter of 2005, he was invited to Holloway to review its detoxification services. The substance misuse adviser submitted a report and in June 2005 commenced a two day per week attachment to Holloway to take forward the recommendations. Areas that he identified as needing work included a variety of staffing issues, such as staff training and development, staff leadership, and team working. The substance misuse adviser was also concerned that opiate detoxification prescribing at Holloway seemed to him to be a 'one size fits all' methadone regime. He is in favour of individual, needs driven, prescribing in line with Department of Health prescribing practices. Upon first arrival in Holloway, women are no longer automatically given medication on demand; instead they are prescribed medication if they have symptoms that require it. The following morning, women have a rigorous assessment and given the course of treatment that is the most clinically appropriate for them. In some cases, that will mean women continuing only with symptomatic medication. In addition, the plan was to commence using Subutex as the usual drug of choice for opiate detoxification – used as a single agent, it is thought

that Subutex is a safer drug than methadone as it does not cause respiratory depression and any adverse reaction to Subutex is not dose related. (Subutex replaced methadone at Holloway in July 2005.)

The substance misuse adviser has reintroduced mandatory clinical observations – blood pressure and pulse – to be taken on every day that a woman is in the detoxification unit. It is also now a doctor's responsibility to deem a person as fit for discharge to normal location. He said that even though a woman has completed her detoxification programme, it does not mean that she is ready for ordinary location – it would not be acceptable for somebody to leave the detoxification unit if she is still experiencing withdrawal symptoms. The plan therefore is for women to remain in the detoxification unit for a further 24 hours to ensure that there are no residual symptoms or any other problems that have not previously been identified. Closer checks are also to be maintained of those women remaining on maintenance doses of methadone following their discharge to ordinary location.

Talking about EMIS, the substance misuse adviser said that within the detoxification unit the recording of information onto EMIS had simply become a 'process', with nurses failing to use it as a communication tool, for instance for recording conversations with patients. There was no audit mechanism in operation to check whether it was being used properly, and no one had taken on ownership for it. Nurses have now been instructed to recommence maintenance of paper records until the EMIS system can be re-evaluated and staff have been fully trained and become competent in its use.

Clinical care

In accordance with the agreement with the Department of Health, the responsible Primary Care Trust (PCT), in this case Islington PCT, was asked to undertake a review of the woman's care in Holloway. I am grateful to them for arranging a multi-disciplinary review in this case and providing a comprehensive report of their findings.

- The woman's declared two-month history of heroin usage was inconsistent with her custodial record. It is very unlikely that she could have become dependent on heroin in the brief interval between her final periods in custody.

- The woman was prescribed methadone, diazepam and chlordiazepoxide. The prescribing of multiple sedative medications is questionable, when the evidence of dependence was so weak.

- The systematic recording of data such as vital signs was not good.

- The repeated entries in the woman's F2052SH about her appearing drowsy should have been raised with senior clinical staff and should have led to a review of her medication.

- The records suggest that a staff nurse made the decision to discharge the woman from H1. The doctor signed the form after the woman had left.

- There is a possibility that the combination of methadone, diazepam and chlordiazepoxide contributed to the woman's death.

- The culture in Holloway at the time of the woman's death did not encourage clinicians to treat patients as individuals.

- There was no programme of training for clinicians in the detoxification unit.

- Holloway does not have a consultant or specialist for substance misuse services.

Islington PCT has identified 12 areas of learning to ensure Holloway has a safe, effective and efficient service for substance misusers. I believe that the Prison Health partnership board needs to consider these and their implementation, if not already actioned.

Recommendation: The Prison Health partnership board should consider the findings of the clinical review and develop an action plan to implement the recommendations.

Clinical drug services

Holloway's previous lead clinician in detoxification services now works for the Department of Health as a specialist adviser in women's drug services. She has had a number of years experience in working with substance misusers in prison, including the period at Holloway referred to above. She wrote her own report about the woman's care and treatment and her main findings were that:

- The woman's electronic patient record did not provide sufficient information to support the assumptions made about her current use of alcohol, opiates and benzodiazepine.

- Entries made in the woman's electronic records about her daily care are lacking in detail.

- Had the woman completed a Self Assessment Questionnaire, this would have provided valuable information about her drug and alcohol use.

- Apart from the baseline observations taken in reception, no record exists that any further monitoring was made of the woman's clinical observations.

- Although drowsiness was reported several times in the woman's F2052SH by discipline staff, there is no evidence apart from on one occasion that this information was passed to the nursing staff.

I am aware that since the woman's death significant development and improvement to the drug services has taken place, and no doubt already addressed many of the issues raised by the previous lead clinician in detoxification. However, she has identified a significant number of learning opportunities and I urge the Prison Health Partnership to consider carefully her report and identify what areas, if any, still need to be addressed.

Recommendation: The Prison Health Partnership Board should review the clinician of detoxification service's report against current service provision and, if required, develop an action plan to ensure safe and effective evidence based best practice.

Summary of the F2052SH review

I am grateful to the review by the Suicide and Self-Injury Prevention Consultant of the F2052SHs relating to four separate periods that the woman was in Holloway. The main findings of which are that:

- Entries in the F2052SH were not always clear, signed, timed and dated.
- Entries were not always meaningful, with entries indicating simple observation of the woman rather than interaction with her.
- Staff appear not to have read and acted upon instructions made in the F2052SH.
- Entries about recommended levels of observation/interaction were not always explicit.
- Staff did not always adhere to recommended levels of observation/interaction.
- Information about provision of support to the woman was not always fully documented.
- A discharge summary was not completed each time the woman was transferred from healthcare to ordinary location.
- Reviews do not appear to have taken place following all incidents of self-harm.
- Management checks did not document areas of concern.
- Observations by night staff were not conducted at unpredictable intervals.
- Healthcare staff did not clearly document their involvement with the woman.

The review concludes: "Since the woman's death, HMP Holloway has transferred to the new procedure for managing prisoners identified as being at increased risk of suicide and/or self-injury (ACCT). It would not, therefore, be fitting to make recommendations in relation to staff's adherence to F2052SH procedures. Whilst there is no evidence to suggest that any lack of adherence to procedures for managing suicidal or self-injuring prisoners contributed in any way to the woman's death, a number of recommendations are made in the context of improving the care provided to this very vulnerable group." The doctor has made eight recommendations in her review.

Recommendation: The Governor should develop an action plan to address the issues identified to ensure a safe system is in place to support and manage those considered to be at risk of suicide or self-harm.

CONSIDERATION OF THE ISSUES

Should the woman have been prescribed methadone?

The woman was not a stranger to Holloway. Each time she was received there she underwent alcohol detoxification.

The woman had been in Holloway continuously from December 2004 to mid February 2005. Having been released then, the woman was back in a few days later before being released four days afterwards. After six days, she once more returned to Holloway. On reception this last time, the woman went through the usual health screening process which included assessment of her use of alcohol and drugs. The woman reported to the prison GP that she was a very heavy drinker. However, she also reported that she had been using opiates. This was not something she had ever reported previously. The woman's urine test was positive for opiates and so prescriptions for alcohol, opiate and benzodiazepine detoxification were written up. The starting dose for the opiate detoxification was 10mg of methadone and she had the first dose that evening.

The following day, the woman saw a detoxification doctor for a more detailed assessment. The woman told the doctor that she had been using heroin for the previous two months. The doctor knew from previous contact with the woman that she did not ordinarily use heroin and she asked her repeatedly about this. However, given that the woman declared that she had been using heroin and that her urine test was positive, the doctor authorised the methadone detoxification programme to continue. In response to my investigators' question about how the woman could have been using heroin for two months when she had been in Holloway for most of that time, the doctor said that there was no guarantee that the woman had not been taking illicit drugs while in prison.

It would seem from the evidence of the prison GP and the detoxification doctor that all that was required for a woman to be prescribed methadone was for her to declare that she was using opiates and provide a positive urine sample. The detoxification doctor completed only a superficial exploration of the woman's declared drugs use and did not challenge her claim that she had been using heroin for two months. The woman had been in Holloway for most of the previous two months and while I am not naïve about the extent of drug taking in prison, it is implausible to imagine that she had been using heroin throughout that time.

The PCT review panel say that it is very unlikely that the woman could have become opiate dependent in the brief time she was at liberty before returning to custody. They go on to say, however, that at the time of her death neither the culture nor clinical governance systems within the prison encouraged or facilitated clinicians to work with prisoners as individuals.

The lead clinician in detoxification services says in her report that further probing was required to have justified the woman's prescribing regime. The lead clinician also criticises the failure to record and monitor the woman's clinical observations.

In retrospect, it seems clear that the woman should not have been prescribed methadone. The fact that such a prescription was written was due, in the main, to the prevailing practices at Holloway at the time. In particular, that there was a standard response to opiate use and the culture did not encourage clinicians to treat patients as individuals.

Should the woman have been prescribed diazepam and chlordiazepoxide?

The clinical review concludes that it was possible for the woman to have become alcohol dependent if she had relapsed into heavy drinking in the brief time she was at liberty before returning to Holloway. In that case, the prescribing of clordiazepoxide would have been justified. However, both the substance misuse consultant from the PCT and the lead clinician in detoxification services argue that the woman would not have become diazepam dependent in this time and so the prescribing of diazepam was probably not warranted.

The woman's reaction to the methadone prescription

My investigators were told consistently by both doctors and nurses that the safeguard with the methadone detoxification programme was that women would be assessed each time they were due to receive their next dose. Anyone assessed as drowsy would have her methadone withheld and a urine test carried out. This happened to the woman on one occasion when her dose of methadone due at 8.30am was withheld until 10.50am. However, this was the only time that the woman did not have her methadone when it was due. The woman's electronic (EMIS) medical record contains a reference to her seeming 'quite spaced out' on the evening of the next day, but this occasion and the time that her methadone was withheld the previous day were the only occasions when any of the nurses in H1 observed the woman to be drowsy. Nurses had the opportunity to assess the woman four times a day when she presented at medication rounds.

The evidence of the nurses contrasts with some of the evidence from the discipline officers. The woman's F2052SH contains references to her appearing drowsy on five occasions in March. At interview, the discipline staff presented mixed views. All of the officers described the woman as drowsy. Some said that she was drowsier than the norm, although others said she was no drowsier than other women going through detoxification. Officers said that they would mention to nursing staff if they had concerns about how someone was coping with detoxification. An officer said that she spoke to a nurse specifically about the woman in early March. However there is nothing recorded in the woman's medical record about this, nor about any of the occasions when entries about drowsiness were made in the woman's F2052SH. Indeed, attempting to obtain any clear picture of the woman during her detoxification was hampered by the lack of meaningful entries in her medical record.

Despite the fact that it is a Prison Service requirement that clinical observations should be taken of prisoners' pulse and blood pressure for at least the first 72 hours while undergoing detoxification, the woman's clinical observations were not taken apart from the day of her first reception into Holloway. My investigators were told that such observations, along with nursing care plans, Self Assessment Questionnaires for prisoners, and completion of withdrawal monitoring charts, all ceased, perhaps up

to a year earlier, due to pressure of work in the detoxification unit. This clearly compromised the quality of continuing care offered to individuals.

By the day of the woman's death her daily doses of methadone had just begun to decrease. The detoxification programme peaked with single doses of 30mg of methadone in the early days in March. On the following two days she received single doses of 25mg of methadone. In his report, the clinical pharmacologist, wrote:

> 'The ability of individuals to tolerate methadone therapy depends on various factors but one key factor is their previous exposure to opiates or opioids. The fact that [the woman] was not used to taking opiates or opioids and was therefore a naïve user of methadone is important in interpreting the concentration of methadone detected in the woman's blood in relation to her death. In a study of ten deaths in subjects who, like the woman, had recently started methadone maintenance therapy, Drummer [found] … the average … blood methadone at post-mortem … was 0.37mg/L … So the concentration of methadone reported … in the woman's blood, 0.4mg/L is consistent with the methadone fatalities described by Drummer. Therefore it would be reasonable, on the balance of probabilities, to attribute the cause of the woman's death to methadone toxicity.'

I can see no reason to demur from the clinical pharmacologist's opinion. Overall, I conclude that the medical supervision and oversight of the woman's detoxification prescribing was of a standard significantly below that which could reasonably have been expected.

The woman's move from H1 to standard location (B4)

In the early afternoon on the day before her death, the woman was moved from H1 to ordinary location. Usually, the woman would have gone to D1, the post-detoxification unit, however D1 was temporarily closed at that time. The local protocol required that before women moved out of H1, a nursing sister or doctor would assess them to ensure they were fit to relocate. Against protocol, it was a staff nurse who authorised the woman's move. This nurse expressed the view that any qualified nurse could authorise the transfer. It is therefore unclear whether the local protocol was even known to the medical staff. Nor did the staff nurse talk to any of the discipline staff about the woman, so the concerns the discipline staff had expressed about her that morning remained unexplored.

When the woman was moved, her F2052SH was not taken with her as should have been the case. It was awaiting completion of the discharge report by a doctor. The escorting officer said that he knew the woman was subject to F2052SH monitoring and he mentioned this to the receiving officer in B4.

Two officers each claimed to have been the receiving officer. Both said that they were unaware that the woman was subject to F2052SH monitoring when she arrived in B4 and when located into dormitory 20. The bed that the woman occupied abutted the room's toilet thereby reducing its visibility from the observation window. It is not clear when the staff in B4 became aware that the woman was subject to special monitoring, but even when this occurred no one thought about the position of the

woman's bed and whether she should have been moved to another that was more visible. This is despite the fact that Prison Service Orders state that a prisoner subject to F2052SH monitoring should occupy a bed that can be clearly observed.

Good practice would be for the discharging nurse to talk to the discipline staff about any issues or concerns they wished to raise about an individual.

Recommendation: The Head of Healthcare should review communication lines to ensure the timely transfer of relevant information pertinent to an individual's care and treatment.

The woman's condition when in B4

The staff nurse who authorised the woman's transfer from H1 to B4 said that the she seemed her usual self that afternoon. The staff nurse made an entry in the woman's medical record that she was fit for ordinary location.

The escorting officer who took the woman from H1 to B4 said that she carried her bag as she went to B4 and seemed no different to any of the other three women moving to ordinary location that afternoon. There had been nothing about the woman to cause the escorting officer any concern about her suitability to move.

There was some inconsistency about the woman's appearance as recounted by the discipline staff in B4. Two different officers claimed to have received the woman into B4. One of them said that when the woman arrived at dormitory 20, she stumbled into the room. This officer said that women going through detoxification were usually disorientated and unsteady on their feet, but that these symptoms were more pronounced in the woman than was normal. The other officer who claimed to have received the woman into B4 described her as no different to any other woman going through detoxification. Another officer did not see the woman when she first arrived in B4. He saw her when she came to the wing office at about 6.30pm for help with some administrative matters. This officer said the woman seemed drowsier and more difficult to communicate with than is typical of someone going through detoxification.

The senior nurse who had seen the woman in reception saw the woman on two separate occasions on the afternoon before she died. The first time was at 4.00pm when she gave the woman her next dose of methadone. The senior nurse said that the woman had not been paying attention when she reached the medication hatch as she was chatting to the other women in the methadone queue. This caused her to sign the medication chart in the wrong place. The senior nurse said that the woman was well at the time, and later that afternoon approached her to apologise for what had happened earlier. Again, the woman seemed well.

My investigators spoke with three of the four prisoners who shared the same dormitory as the woman. All three described the woman as very drowsy. Two described her as being more drowsy than usual for those going through detoxification.

Another prisoner from B4 was standing behind the woman at the time of the final medication round at 7.30pm. This prisoner said that the woman was already drowsy and she queried why the woman was being given even more medication.

The officer, who was supervising the medication queue heard what the prisoner said but did not think that the woman was different to any other woman going through detoxification. Nor did the nurse who actually issued the woman's medication at that time.

The night before the woman's death

The dormitory doors were locked at around 8.00pm. It would seem that the woman fell asleep not long after. The other prisoners in the dormitory said the woman was making a lot of noise in her sleep, snoring quite loudly and/or coughing. At around 11.00pm, one of the prisoners woke the woman because of the noise. The woman had seemed quite well at that time and asked for a cigarette.

An OSG, the night officer, said she noticed the woman breathing very heavily at around 3.00am, but there had been nothing to give her any cause for concern. The OSG said that, despite the position of the bed, she could see the woman from her shoulders down (this does not accord with the opinion of my investigators who thought that only the lower half of the woman's body would have been visible). I am uncertain, therefore, whether the OSG was able properly to observe the woman through the night as required in accordance with F2052SH monitoring procedures. However, I acknowledge that she had been placed in a difficult position given that the day staff had not asked the woman to change beds when they became aware that she was subject to special monitoring.

The lead clinician in detoxification services pointed out in her clinical review that noisy breathing can suggest opiate toxicity. Staff in B4 might not have been aware of this. The lead clinician concluded that it is more likely that this symptom would have been recognised/noticed in a second stage detoxification unit as opposed to ordinary location.

The morning of the woman's death

At 7.15am, the OSG carried out what should have been a check that all prisoners were present and were well and not a simple head count. Although the OSG's F2052SH entry indicated that she had obtained a response from the woman, she said at interview that she had in fact relied on the other women in the dormitory telling her that the woman was asleep.

Before night officers are permitted to go off duty, oncoming day staff must carry out their own count to satisfy themselves that they have taken over the correct number of prisoners, all of whom are well. An officer acknowledged that, while she counted the prisoners, she did not obtain responses from all of them. She said that it was usually impractical to obtain responses from all of the women, but she should at least have obtained responses from the women on open F2052SHs.

Although it was the officer who made the count who recorded the numbers in the wing file, it was another officer who wrote in the woman's F2052SH that she had responded when checked by the other officer. His explanation for doing so was that completion of F2052SHs was often a team task.

The discovery of the woman's death

When medication was being issued at about 8.30am, one of the women in the dormitory tried to wake the woman. On doing so, the prisoner realised that the woman was dead and alerted the staff. Staff entered the dormitory, radioed for assistance and checked the woman for presence of vital signs. Nursing staff responded quickly and resuscitation was attempted, but all efforts were to no avail.

Descriptions of the woman's condition when found all indicate that she had been dead for some time. Nevertheless, certain aspects of the response to the code blue alert warrant comment. The first response nurse was clear in her mind that when she reached the room about one minute after the code blue had been issued and there were no staff around the woman's bed. This does not accord with the evidence of the first staff on scene who said that they were in the midst of checking the woman at the point that the first response nurse arrived and took charge of the situation. I cannot resolve this conflict in the testimony.

Upon the first response nurse's arrival, the dispensing nurse went to the level 4 nurses' station to collect the blue bag. Due to the lack of space in the nurses' station, the blue bag is mounted on a wall. The height of that mounting combined with the weight of the bag meant that the nurse was unable to take the bag down and an officer had to go to the nurses' station to do this for her. The investigators were also told that level 4 does not have its own defibrillator, so one had to be collected from another level. When it was used, it instructed that the woman should not be shocked.

Recommendation: The Head of Healthcare should review the location and storage of equipment to ensure it is easily available when required in the event of an emergency.

At the debriefing of the morning's events, one of the two ambulance crews reported that they had had some difficulty in gaining access. It seems the reason for this was that only one member of staff acted as a guide and escort to the ambulance crew.

Recommendation. The Governor should review Holloway's arrangements for escorting emergency ambulances to ensure that they arrive at the appropriate location with the absolute minimum of delay.

Developments since the woman's death

Since the woman's death, two senior healthcare staff have been involved in reviewing healthcare provision at Holloway, including Holloway's delivery of detoxification services. One of the major changes introduced is the replacement of methadone by Subutex as the principal drug of choice for opiate detoxification. Subutex is judged as being a safer drug than methadone as it does not cause respiratory depression. A senior member of healthcare staff told my investigators that women now remain in H1 until they have completed their detoxification programme and have their clinical observations taken throughout their stay in the unit. It is now a doctor who is responsible for authorising transfers from H1 to standard location. Both of the senior healthcare staff also told my investigators about investment in certain staffing issues, such as staff training and development.

RECOMMENDATIONS

1. The Prison Health Partnership Board should consider the findings of the clinical review and develop an action plan to implement the recommendations.

2. The Prison Health Partnership Board should review the clinician of detoxification service's report against current service provision and, if required, develop an action plan to ensure safe and effective evidence based best practice.

3. The Governor should develop an action plan to address the issues identified by the doctor to ensure a safe system is in place to support and manage those considered to be at risk of suicide or self-harm.

4. The Head of Healthcare should review communication lines to ensure the timely transfer of relevant information pertinent to an individual's care and treatment.

5. The Head of Healthcare should review the location and storage of equipment to ensure it is easily available when required in the event of an emergency.

6. The Governor should review Holloway's arrangements for escorting emergency ambulances to ensure that they arrive at the appropriate location with the absolute minimum of delay.