# Investigation into the circumstances surrounding the death of a woman at HMP Peterborough in March 2008

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

**October 2008**

This is a report on the circumstances surrounding the sudden death of a woman at HMP Peterborough on 5 March 2008. The woman had been recalled to prison on 6 February after breaching her licence conditions. On the morning of 5 March, she was discovered collapsed on the floor of her cell by a fellow prisoner. The prisoner alerted staff who quickly attended to her and established that she needed immediate medical care. On arrival at the cell, healthcare staff administered cardio pulmonary resuscitation until the paramedics arrived and took over. Despite their continued efforts, the woman failed to respond and was declared dead at 8.00am. She was only 35 years old. I would like to offer my sincere condolences to her family and friends for their loss.

One of my colleagues carried out the investigation on behalf of the Ombudsman. I would like to thank the Director of Peterborough Prison, and his staff for their co-operation and assistance with the investigation. In addition, Peterborough Primary Care Trust appointed a doctor from a nearby practice, to conduct a clinical review into the woman's medical care while in custody. I am grateful for his report.

The investigator wrote to HM Coroner to inform him of the investigation and request a copy of the post mortem report. The initial post mortem was inconclusive. Subsequent toxicology results revealed the cause of the woman's death to have been as a result of the combined effects of methadone and diazepam taken at the levels she had been prescribed. There was no indication that her death was intentional and no clear reason is apparent for her medication to have had such a tragic and fatal effect. In the clinical review, there are references by the reviewer to the possibility of the woman storing her medication. However, information that was not available to the reviewer at the time of his report indicates that this would have been unlikely.

I make one recommendation in relation to clinical record keeping, but I am satisfied that the woman's health needs were appropriately addressed. I am also satisfied that the actions of prison staff caring for her were appropriate.

**Jane Webb**
**Deputy Prisons and Probation Ombudsman** **October 2008**

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## SUMMARY

The young woman was sentenced to eight years imprisonment in 2002. She was released on licence in November 2006, but returned to drug use and found herself returned to custody after further offending. In July 2007, she was again released on licence from HMP Peterborough. She resided at a probation hostel in Leicester and, during this period, she actively engaged with the Criminal Justice Drug Team as part of her licence conditions.

On 5 February 2008, following her arrest for alleged theft, she was recalled to custody at Peterborough. On reception, the woman was said to be visibly upset by her recall and was adamant that she did not know the explanation. The health screening revealed that she had been prescribed methadone, diazepam and tramadol for pain relief due to a back injury sustained some years earlier. The doctor placed her on a methadone maintenance programme and a gradual reduction detoxification of the diazepam over a four week period. The tramadol was stopped immediately. The woman was not happy with the changes to her medication as she felt that the tramadol should have been replaced by something else to manage her back pain. She was also keen to cease the use of methadone for pain relief so the nurse referred her to the pain management clinic at the local hospital.

When she returned to custody, she initially felt low and was subject to Assessment, Care in Custody and Teamwork (ACCT) monitoring. The ACCT process provides additional support and care for those at risk of self-harm. The woman's mood improved over the next few weeks. She found employment on the painting party and was said to enjoy the work.

During the early morning roll check on 5 March, a Prison Custody Officer (PCO) saw her lying on her bed at 5.30am. Another PCO saw her at around 6.30am, while completing another roll check. The PCO noted a slight movement but received no verbal response. At 7.15am, the woman's cell was unlocked and a friend went to her cell. When her friend tried to enter, she found the woman lying on the floor behind the door. She alerted staff who responded immediately. They quickly established that she required medical help and requested assistance.

The first nurse arrived at around 7.20am and began to check the woman's responses. The lead nurse quickly joined her and asked staff to ensure that an ambulance had been called. The nurses then administered cardio pulmonary resuscitation (CPR), with the assistance of the orderly officer. A defibrillator was subsequently applied which indicated that there was no output (rhythm from the heart or a pulse) and CPR was continued until the paramedics arrived at 7.33am. They continued to attempt resuscitation but she failed to respond. A paramedic declared her dead at 7.51am.

Managers at the prison visited the woman's partner to inform him of her death. A memorial service was held and assistance with funeral expenses was offered. I am satisfied that the woman was appropriately cared for. I make one recommendation regarding record keeping.

## THE INVESTIGATION PROCESS

1. The investigator, opened the investigation on 10 March 2008. Notices for staff and prisoners were provided to the prison informing them of the investigation and inviting anyone with relevant information to come forward. No responses were received.

2. The woman's partner, contacted the office and the investigator spoke to him on 12 March. During their conversation, her partner informed the investigator of the funeral date and the investigator explained the Ombudsman's investigation. He also informed the woman's partner that one of the Ombudsman's Family Liaison Officers (FLOs) would make contact with him after the funeral.

3. On 19 March, the investigator visited HMP Peterborough where he met a manager who was acting as the liaison with my office. The investigator visited the residential unit where the woman had lived and saw her cell. The manager told him that the funeral had taken place the previous day and both he and the Director had attended. The manager also confirmed that the woman's personal property had been returned to her family, apart from some items that remained in her cell.

4. Having been assured that all necessary documents had been sent to him, the investigator found it necessary to contact the prison on numerous occasions over the following two weeks as the documents had not been delivered. It was eventually established that owing to some confusion, the courier service had returned them to the prison. The investigator arranged to visit Peterborough again on 31 March in order to collect the paperwork. It is unfortunate that these problems led to my investigator being unable to arrange staff interviews at an earlier stage.

5. As well as reading the records, the investigator also viewed closed circuit television coverage (CCTV) of the part of the prison occupied by the woman.

6. The same day as the visit to Peterborough, an FLO, from the Ombudsman's office, visited the woman's partner, accompanied by the investigator. Her partner, spoke of his concerns about the reasons for her recall to prison, as well as issues relating to her medical treatment. He provided my investigator with copies of letters he had sent on the woman's behalf regarding her medication and other matters after her recall. He also spoke about the woman's son, who at the time was a serving prisoner at another prison. He explained that her son had asked him to be the point of contact for my office in matters relating to the investigation.

7. On 9 April, the investigator contacted the woman's probation officer, who had been supervising the woman, in order to gain some background to the reasons for her recall. The probation officer explained that he had known the woman for some time and talked at length about his dealings with her. He agreed to forward to the investigator information that he felt might be helpful to the investigation.

8. A doctor representing Peterborough Primary Care Trust (PCT), was asked to conduct a review of the clinical care the woman received at Peterborough. The review was completed without the benefit of a post mortem report and sent to the Ombudsman on 10 June. The investigator subsequently received the post mortem report and forwarded a copy to the doctor. In the light of the post mortem and toxicology results, the investigator requested further information from him. However, at the time of publishing the draft report no response had been received. The doctor's report is attached as an annex to this report.

9. A member of the Independent Monitoring Board (IMB) at the prison in which the woman's son was being held contacted my investigator on 12 June. The woman's son was concerned about the investigation process. The Ombudsman's FLO, and another investigator, visited the woman's son to discuss his concerns.

10. Following the visit the investigator telephoned the son via staff at his prison to explain the investigation process in more detail and to clarify points he had raised. The investigator also contacted the coroner's officer on the son's behalf to notify him that he wished to be treated as an interested party and to arrange for a copy of the post mortem report to be sent to him. It was also arranged for the son to receive a copy of the report and for his Senior Officer at the prison to help him with it.

11. I would like to thank the Senior Officer for his help in ensuring the woman's son has been able to contribute to this investigation and obtain all relevant reports immediately.

12. After the draft report was issued, both the Prison Service and the woman's family responded identifying some factual inaccuracies that have now been rectified. The woman's family also had further questions regarding aspects of her treatment. I have where possible attempted to address these points and provide more clarity where possible. However, there were a number of questions raised in relation to the findings of the post mortem on which I feel unable to make further comment.

## HMP PETERBOROUGH

13. HMP Peterborough is privately run by Kalyx (formerly UK Detention Services). Opened in March 2005, it is the newest purpose built prison in the United Kingdom. It is also the only prison that holds both men and women, who are kept separate at all times. This factor makes it a very complex prison to manage. Its role is that of a category B local prison serving the counties of Cambridgeshire, Nottinghamshire, Lincolnshire, Leicestershire, Northamptonshire, Norfolk and Suffolk.

14. HM Chief Inspector of Prisons, Ms Anne Owers, conducted an announced inspection in October 2006. One of the main concerns of the inspection team was the provision of healthcare, of which the team concluded:

> "Among the worst we have seen for some considerable time. At every level from the administration of medicines through to primary and in-patient care there were serious deficiencies, with under trained and inadequately managed healthcare staff unable to provide a safe and decent service."

15. Since the inspection, efforts to improve the provision of healthcare services at Peterborough have been made. My investigator found the level of care and quality of documentation was good.

16. The inspection team also commented on the provision of substance misuse workers. In relation to methadone, Ms Owers said:

> "Methadone regimes were fairly positive, offering a six-day period of stabilisation followed by a review and leading to detoxification or maintenance. The latter, however, was available only while women were on remand or for up to three months post-sentence. At the time of the inspection there were 102 women receiving methadone, 29 on detoxification and 73 on either stabilisation or maintenance."

17. The Independent Monitoring Board (IMB) at Peterborough published their first report on the new prison in March 2006, a year after it opened. Previously known as the Board of Visitors, the IMB independently monitors all aspects of day to day prison life, including considering prisoners' complaints. Each board will produce an annual report focusing on the strengths and weaknesses of their particular prison. In relation to the provision of healthcare the Peterborough IMB's report said:

> "The development of the healthcare services in the new prison with a population including male and female prisoners, and a Mother and Baby Unit has been a major challenge for UKDS. Unlike Public Prisons where the responsibility for the provision of the service is the local NHS trust, Contracted Prisons are the responsible providers. UKDS has had the foresight to work closely with the Peterborough Primary Care Partnership (PCP) and has established a Service Level

Agreement with the PCP using NHS staff at all levels and specialities to provide the service. The model for the service is that of a community general practice with recognition of the special problems in a prison population, and the need to provide a similar service to two units.

"The male/female Health Care Centres both offer daily GP Clinics, nurse led Clinics, and Wing triage rounds as well as dispensing listed drugs in the Centres to prisoners requiring observation during administration. The typical workload is about 35 seen by GPs, and 45 by the nurses daily on each side. Unlike community practice the major issues are substance abuse, depression and anxiety and other more serious mental health problems. The Board congratulates the Staff, often with no experience of working in prison, in the progress that has been made to achieve a level of service comparable, and in some cases exceeding, that of NHS care in the community.

"There are some areas requiring further development. The GP/Nurse waiting list times is about three days which does not meet the NHS guidelines although more urgent problems are seen sooner. It is sometimes difficult for the staff to have accurate information about new prisoner's health issues and medication, which can lead to problems and result in delays and often complaints. A greater effort to establish Health Promotion is needed.

"However we welcome the new Well Woman/Man Clinics that have been set up as well as the specialist nurse led asthma and diabetes clinics. There is a need to get more substantive IT services in order to conduct better audit and clinical governance practices. The IMB is represented on the Health Needs Assessment Group which will report to the PCP/HMP Partnership."

18. Since Peterborough opened in 2005, there have been three previous deaths in custody. One of these was self inflicted and the other two attributed to natural causes. There are no previous recommendations from these deaths that relate to this investigation.

## KEY FINDINGS

### The woman's custodial history

19. As mentioned earlier in this report, the woman began offending in her early teens and it became progressively serious and culminated, in 1993, in consecutive custodial sentences totalling ten years. Despite this lengthy period of custody, she returned to crack cocaine and heroin use when she was released in 2001. This resulted in her re-offending, but on these occasions she was given Drug Treatment and Testing Orders (DTTO's) in February and March 2001, as an attempt to tackle the roots of her offending. However, while subject to these orders, the woman committed further offences that resulted in the DTTO's being revoked on 20 July 2001.

20. As a consequence of the breach of the DTTO's and further offences of theft, the woman was remanded for three weeks to HMP Holloway. She was sent to Crowley House Probation Hostel in June 2001 for a period of bail assessment. In the first few days, the woman responded positively to the opportunity she had been given and settled in well at the hostel. However, after the first week she started to use heroin again, which resulted in a final warning by staff at the hostel. At the end of June, the woman breached her licence by committing further offences. When she found out that she would have to return to custody, she absconded from the hostel and remained at large in the Birmingham area.

21. In July 2001, the woman was arrested for serious offences and again found herself in custody. She later said that they had been committed while under the influence of drugs. She was sentenced in February 2002, to eight years imprisonment.

22. She was released on licence from HMP Peterborough in November 2006. Following her release, she again returned to drug use and was arrested for theft. After her arrest, she tested positive for both opiates and cocaine. For these offences, the woman was sentenced to 28 days to be served with the remainder of her sentence. In July 2007, when she was released on licence from Peterborough, she went to a probation hostel in Leicester.

### The woman's period at Kirk Lodge from 25 July 2007 – 5 February 2008

23. Following her release from custody, the woman indicated that she wanted to address her drug habit. Her supervising probation officer, who had known her since her previous period of licence in 2006, was supportive. He told the investigator that she had not been so positive on previous periods of licence.

24. The woman's drug tests were negative and she was free of drugs for the longest period since the age of 13, actively engaging with the Criminal Justice Drug Team (CJDT). She also started to work for an employment agency, in a temporary position, with a view to being offered a permanent position after 13 weeks. This was the first time in her life that she had been given a job.

25. However, this period was not without problems and, in October, she was arrested for theft. While in police custody, the woman tested negative for class A drugs. In explaining her reasons for the offence, she told her probation officer that she had been threatened by people who she used to know as she owed money to them. In recognition of her improvements, no action was taken regarding her breach of licence. Her supervising officer, prepared her pre-sentence report and emphasised the change in her character and the positive steps that she had taken to address her drug addiction. The court gave her a Suspended Sentence Supervision Order (SSSO), when she appeared on 29 October 2007.

26. Following the court case, the woman's positive progress continued. She also met her partner, with whom she travelled to and from work. They became close which offered her the stability she had not had before and they had discussed marriage. However, her partner was forced to give up work due to illness. Subsequently, she was unable to travel to work as she could not drive and had to give up her job as well. Nevertheless their relationship progressed and they made plans to move in together when she was given permission to leave the probation hostel.

27. On 5 February 2008, the woman was arrested on suspicion of theft. Although not formally charged, she was bailed to appear on 26 February. Following her release from the police station, the woman contacted her probation officer to tell him what had happened and admitted that she had committed the offence. In view of this information, he discussed the situation with his supervisor and an Assistant Chief Officer. It was decided that, in view of her further offences, it was necessary to impose a curfew denying her the right to go out at night. The curfew also affected her move on from the probation hostel. The probation officer and his managers considered that, when faced with these decisions, it would be clear to her that her recall to custody was inevitable. Ultimately, the decision to recall the woman was made by the Early Release and Recall (ERR) Section based on the information supplied to them.

**The woman's return to HMP Peterborough**

28. Following the recall decision on 5 February, she returned to Peterborough the next day and was taken through the normal reception procedures. It is normal practice for prisoners sent to Peterborough to be located initially in the healthcare centre for observations.

    *Following sight of the draft report, the woman's family asked about an entry in her medical notes referring to a request by her for a pregnancy test on 7 February, and whether this was carried out.*

    *It is normal in female prisons for women to be routinely offered a pregnancy test as part of their health screening on entry into prison. The woman would have been offered one during her second health screening and notes indicate that she requested it. However, the investigator has been unable to find any indication that the test was carried out.*

29. She had taken methadone for a number of years, since it was originally prescribed at HMP Foston Hall. The reason for the initial use was to manage her opiate addiction. However, methadone is also used to manage chronic pain. The woman had sustained a back injury in a car accident some years earlier and methadone was prescribed to relieve her continuing pain.

30. Drug tests performed by healthcare staff at reception proved negative for everything other than prescribed medication. This was significantly different to other periods in custody when she had tested positive for illicit drugs on reception. A second health screen was carried out the following day. The woman was put on a methadone maintenance programme in which she would receive 40mls a day. Due to the risks of becoming dependent on diazepam, she was also put on a diazepam detoxification programme, which involved a gradual reduction from 10mg to 4mg over a four week period. Prior to custody, she had also been receiving tramadol but this was stopped following her reception. The screening also recorded her other medical history, which included asthma, hepatitis C and swelling in her legs, believed to be as a result of intravenous drug use.

31. Following the observation period on the healthcare wing, the woman was placed in A wing. She was visibly upset when she went to the wing and an ACCT document was opened as a result. During the assessment, she said she did not understand why she was back in custody, despite her conversation with her probation officer after her arrest. She appeared very frustrated and tearful but said that she had no thought or intention to self-harm. The woman was also concerned that no one including her son knew that she was in custody.

32. After the assessment, a review was held with the woman and the unit manager. The woman was upset throughout the review. She was adamant that she was not going to self-harm but was frustrated at her recall. She requested a move from A wing to the Voluntary Drug Testing (VDT) landing and was provided with the necessary application form. She also asked about contacting her son, but was told that proof would be required that he was being held at the prison specified. When the investigator spoke to the woman's partner, he said that this decision caused her some frustration. He explained that she had made contact with her son on previous sentences. It was known by the prison that he was in the prison she had stated and she could not understand the need for further confirmation. The decision was taken to keep the ACCT open for the time being.

33. On 13 February, a Security Information Report (SIR) indicated that the woman was acting in a strange way which made staff think that she might be under the influence of drugs. (SIRs can be submitted by any member of staff working within a prison who has concerns about anything related to the security of the prison.) Other remarks were made during her first few weeks in custody relating to her possibly using drugs. However, they were not substantiated and the woman's drug tests were negative, rendering her eligible for a move to the VDT wing. This was the longest period that she had abstained from illicit drugs as she had used drugs heavily during previous prison sentences.

*Following sight of the draft report the woman's family asked whether other avenues should have been explored to explain her behaviour, given that there was no evidence that she was using illicit drugs.*

*I do not think staff could have been expected to make any further enquiries into this matter on the basis of so little information. The woman had provided negative urine samples and had not mentioned any other concerns to staff.*

34. Over the next week, her moods fluctuated and she mentioned to staff several times that she was confused about the reasons for the recall. It is evident from the ACCT document that staff tried to advise her about this but she would get herself "very wound up". An ACCT case review, held on 15 February, said that the woman interacted well, but still appeared very emotional. She remained concerned about her recall, as well as issues with some women on another wing which meant that she was worried about moving.

35. On 18 February, she submitted a request and complaint form in relation to her medication. She was concerned that the diazepam was to be withdrawn and said that she needed it for her back pain. She also said that she wished to stop taking methadone and be prescribed tramadol instead. It is clear from the complaint form that the woman thought her concerns about her healthcare were not being taken seriously.

36. Her probation officer wrote to her on 18 February, to set out the reasons for her recall. He explained that he remained optimistic and recommended her release on the same licence conditions. He explained how positively she had progressed during her licence period. Her probation officer went on to explain that he would visit soon but she should know that he would continue to do his best for her.

37. ACCT entries indicated that she appeared happier and was told that she could move to the VDT wing. She had been pursuing the plan since returning to custody. However, an entry in her medical record on 19 February gave a different view. It was recorded that during an appointment the woman had been "very distressed and anxious" and that she had "become quiet and withdrawn but she was not thinking of self-harm". She also reiterated that she did not know why she had been recalled.

38. The Clinical Lead Nurse, responded to the woman's request and complaint on 20 February, advising her to make an appointment to discuss her problems. The Clinical Lead Nurse had known the woman for some time and saw her regularly in the clinic for blood tests. The investigator spoke to the Clinical Lead Nurse about the woman's medication. She said:

> "The woman was taking methadone, not because of heroin addiction but because she had pain in her back, so that was an ongoing situation with her. She wanted to be detoxed off it, and our detox nurse was reluctant to do it at that time as she felt her back pain could get worse,

and she wanted her to be seen by the Pain Specialist Nurses prior to detox."

39. On 22 February, the woman began working on the painting party. Her personal officer, recorded that at first she was surprised to be allocated to this job, but appeared to enjoy the work. It also gave her more time out of her cell. The personal officer scheme allocates prisoners a particular officer who they should go to regarding any immediate concerns or issues. The personal officer will usually be responsible for commenting on the individual's behaviour for reports and accompany them during reviews of ACCT documents. Most importantly, they are a point of contact if a prisoner just needs to talk.

40. The investigator asked the woman's personal officer about her contact with her:

> "I would see the woman on a regular basis, I was also available for her should she need to call for me to come and speak to her, which I would do if I was available to do so. It would be fair to say that we had a close relationship. On this sentence, she appeared to me to be very much the same as I had previously known her. However, the licence recall caused her quite a bit of distress and she was upset about why she had been recalled when she first came in."

41. The personal officer attended an ACCT review with the woman on 22 February. She interacted well during the review. Her only concern was that she would be moved from A wing and was awaiting a decision on whether she could go to C wing. However, an earlier entry in her ACCT suggested that she had already been notified that she had been accepted. A date was set for the next review to take place on 3 March.

42. On 23 February, one of the prison chaplains and the woman discussed the possibility of her marrying her partner whilst she was in prison. The chaplain agreed to speak to her partner and the local priest about her request.

43. The woman went to see the doctor on 25 February about swelling in her legs. The doctor acknowledged that she had previously suffered from severe swelling in her ankles, but this was not present during the examination. He recorded that she had minimal swelling in her left ankle. She was prescribed the anti-inflammatory drug, diclofenac, to treat the swelling. She was advised by the doctor that diclofenac can aggravate asthma in some patients. After seeing the doctor, the ACCT document says that the woman was feeling down. However, the document says that she was happier when she returned from work in the afternoon as she enjoyed being on the painting party.

44. While in custody, she received regular visits from her partner, and would often talk about them when she returned to the wing. On 28 February, a member of the chaplaincy team spoke to her and her partner during a visit and briefly discussed their plans to get married. It is recorded in the ACCT document that she became upset during the visit and, when she returned to the wing, she told staff it was because she missed her partner.

45. Her partner wrote to the Clinical Lead Nurse on 28 February. He was concerned that no one in the healthcare department was listening to the woman's concerns about medication. When my investigator interviewed the Clinical Lead Nurse, she acknowledged that she had received this letter. However, the woman's partner did not receive a reply to this letter or indeed the questions asked and he felt that this was discourteous.

46. On 29 February, the woman replied to her probation officer's letter of 18 February. She discussed the offence that had led to her recall and how she had tried her hardest, but accepted she had been foolish. She also spoke fondly of her son and her partner and said that she was determined to remain positive. The woman closed the letter by thanking her probation officer for doing his best for her and said that she knew that he would do so again.

47. Over the next week, she continued to be in good spirits. She spent time laughing and joking with other prisoners and staff. She asked on a number of occasions for her ACCT monitoring to be stopped as she felt a lot better. The painting party kept her busy during the day and proved positive for her. On 30 February, the woman told staff that her solicitor had written to her local Member of Parliament about healthcare staff not allowing her to take an alternative to methadone. However, the investigator was unable to substantiate whether she had sent this letter.

48. The woman's next ACCT review took place on 3 March. During the review, she interacted well and her mood was very positive. She said that she was enjoying the painting party but was disappointed that there was to be a two week break. She said that she was awaiting authorisation for an inter-prison video link communication with her son. (Many prisons now use video systems to link to Crown and Magistrates' courts. Prison Video Links [PVLs] allow offenders to appear in court via a live video link from prison. PVLs are primarily used for court hearings and legal visits, but they can also be used for a number of other purposes such as probation and official visits, inter-prison visits and staff training.)

49. Healthcare confirmed that they had no concerns regarding the woman and the decision was taken to close the ACCT. She was pleased about this and a post closure interview was planned for 10 March. The post closure interview is used to check on anyone who has been the subject of an ACCT document, and it should be conducted within seven days of closure.

50. Following a request from the woman to speak with a member of the Independent Monitoring Board (IMB), two members went to see her on 4 March. The woman raised a number of concerns, the first regarding the recall documents she said she had completed, but had not been received by her solicitor. She was also concerned that her probation officer had not yet been to see her and showed them the letter written by him on 18 February. The woman also discussed her prospective marriage to her partner and said that she had submitted the paperwork to the Deputy Director for it to go ahead. Finally, she told the IMB members about her concerns about the methadone she had been

receiving. She was insistent that she had no intention of using drugs again and therefore did not want to be prescribed methadone.

51. Following their meeting with the woman, the IMB members returned to the IMB office. One of them attempted to contact the woman's probation officer but he was unavailable, and so left a message expressing the woman's concern. In the record of their meeting, the IMB member's say that their impression of the woman was that she was agitated and bordered on being hyperactive. They said that the woman appeared anxious throughout and wanted everything sorted out. She also said that it was not possible to say whether her expectations were realistic or if she had given adequate time for them to be resolved.

*In response to the draft report, the woman's family said they were puzzled by the IMB's conclusion as to whether her expectations were realistic. The family also asked about the role of the IMB.*

*The woman had said that she had sent various applications regarding a number of issues during her talk with the IMB. I believe that when mentioning realistic expectations, the IMB members were concerned that she was not allowing enough time for people to respond to her requests.*

*The Prisons Act 1952 requires every prison to be monitored by an independent board, appointed by the Home Secretary, comprising members of the community in which the prison is situated. The board is required to satisfy itself as to the humane treatment of those held in custody and the range and adequacy of the programmes preparing them for release. The members have the right of access to every prisoner and every part of the prison to ensure proper standards of care and decency.*

52. The investigator observed the CCTV footage of the woman's wing filmed on the evening of 4 March. She was unlocked for association and spent the majority of her time in or around her cell. She left her landing on only two occasions, to collect hot water and use the telephone. She could be seen talking to her friend, and looked in good spirits. The cells were locked up at around 7.30pm. The woman was seen in her cell at the final roll check around 9.00pm. During the remainder of the night the CCTV footage shows that she made no requests via her cell call bell for staff.

*The woman's family has also asked whether there was evidence that the cell call system was working correctly.*

*Although the investigator was not provided with any evidence to show it had taken place, a check of all cell call systems is conducted daily as part of the cell fabric check. As previously mentioned, the CCTV showed no call being made from her cell. Given the location of her cell, if a there had been a problem she would have been able to raise concerns verbally. However, when interviewed, her friend, who was in a cell next to her, said that she did not hear the woman during the night.*

53. At approximately 5.30am the following morning, a PCO, who was on the night shift, was conducting the early roll check. The PCO is a permanent night officer and was familiar with the woman as he had carried out checks on her while she was subject to ACCT monitoring. When he arrived at her cell on the morning of 5 March, the PCO checked as normal. However, the investigator noticed on the CCTV that he appears to have done a "double take". The investigator was keen to know why the PCO did this and spoke with him when he visited Peterborough. The PCO told my investigator that he had been doing his count as normal and, on arrival at the woman's cell, had opened the observation panel to check before moving on. However, at first glance he was not satisfied that he had seen her and, knowing that she had only recently been taken off ACCT monitoring, decided to have a better look. He said that on looking into the cell he could clearly see her lying on her bed and she appeared asleep. He therefore had no cause for concern and moved on.

**Discovery of the woman and medical treatment**

54. At 6.00am, another PCO started duty as the early unlock officer. The early unlock PCO was responsible for ensuring that all prisoners required for court were unlocked and taken to reception, as well as carrying out a full roll check. He began to count the woman's wing at approximately 6.30am, but on arrival at her cell, he could not see her in bed. He told my investigator that he looked again and she was clearly not there so he looked to the side and could see her on the toilet. The early unlock PCO told the investigator that having seen the woman, he did not continue to observe as a matter of decency. He noted, however, that she was sitting forward with her forearms resting on her lap. The early unlock PCO said that he also noted movement of her hands.

55. Following the early unlock PCO's roll check, there was a period of around 40 to 45 minutes before staff began to unlock the wing. At 7.15am, two day duty PCO's unlocked the servery workers on A wing before unlocking the remainder of the wing. One of the PCO's unlocked the upper landing where the woman was located. (When male staff unlock women prisoners it is important to ensure that levels of decency are maintained, so when they unlock the cell doors they do not push them open.) He unlocked the entire landing and went back downstairs.

*The woman's family asked whether it was usual practice for staff to look into a cell to ensure that it is safe to unlock the door.*

*I agree that staff are usually encouraged to observe a prisoner by way of the observation panel before entering their cell. However, it was not the PCO's intention to enter the cell. He was only releasing the lock on the woman's door, this would not have required him to observe her before doing so.*

56. The woman, and her friend, who was on the same landing used to take it in turns to go to each others cells for coffee in the mornings. The woman's friend told my investigator that on the morning of 5 March it was her turn to go to the woman's cell. When she pushed the door to the cell she saw the woman lying on the floor right behind the door. The woman's friend told the investigator that

it looked to her as though the woman had fallen from the toilet. On seeing her, she went to the top of the stairs and called to the PCO's to come to the cell as it looked as though her friend had collapsed.

57. On entering the cell, the PCO found the woman lying on the floor and called the other PCO for assistance. The woman was lying on her front and the officers placed a blanket over her lower half. Both officers checked for a pulse and called for medical assistance via the radio. On hearing the call for assistance at around 7.20am, a Senior PCO (SPCO) made her way to the woman's cell. She also checked for a pulse and called again for medical assistance. When asked to clarify how long it was before such assistance arrived, the SPCO said it was "a couple of minutes perhaps not even that".

58. A nurse was the first member of healthcare to arrive as she had been issuing medication on a neighbouring house block. She asked staff to call Clinical Lead Nurse, whom she had heard join the radio network as Hotel 1. (Hotel is the radio call sign assigned to medical staff and the staff member carrying Hotel 1 is the first to respond to a healthcare emergency.) The nurse said she checked the woman's pulse and could detect no output. Within a couple of minutes, the Clinical Lead Nurse arrived at the cell. She instructed the staff to make sure that an ambulance had been called and that it was given quick access to the wing. The nurse told the Clinical Lead Nurse what was happening and together they put the woman onto her back. The nurse began chest compressions and the Clinical Lead Nurse gave breaths to the woman. The Orderly Officer (the Orderly Officer role is carried out by a senior uniformed grade who is responsible for attending all incidents), arrived at the cell and took over assisting the Clinical Lead Nurse and the other nurse left the cell.

59. The Clinical Lead Nurse prepared the defibrillator and placed the pads on the woman's chest. The machine automatically assessed her and indicated that there was no "shockable rhythm" so staff continued cardio pulmonary resuscitation (CPR). The Clinical Lead Nurse and the Orderly Officer continued to administer CPR, stopping to check the defibrillator every couple of minutes. The machine continued to show there was no "shockable rhythm" and they continued CPR until the arrival of the paramedics.

60. The Clinical Lead Nurse told the investigator that the paramedics arrived about ten minutes after she got to the cell. Two ambulances answered the emergency call and a paramedic trained to recognise and pronounce death, was with one of the crews. They treated the woman as a patient who had suffered cardiac arrest. The ambulance records show that their treatment began at 7.33am. However, she failed to respond and all treatment ceased at 7.51am, when the paramedic declared that the woman had died.

*The woman's family said that the report from the ambulance crew indicated that she was last seen alive at 6.00am. They consider that this is at odds with the evidence.*

*The report by the ambulance service reads "last seen at 06.00 during morning checks". I agree that this statement could be misleading. The PCO's duty*

*began at 6.00am and it was approximately 6.30am when he reached the woman's cell during his roll check.*

**Following the woman's death**

61. Later that day, managers from Peterborough prison visited the woman's partner, at his home to notify him of her death. They informed him about the circumstances surrounding the woman's death as far as they were known and about the involvement of my office. The prison also offered assistance in meeting funeral costs.

62. The prison had a lot of contact with him during the weeks following the woman's death. Her partner was keen to get her personal effects back before her funeral, along with other property, and the prison ensured that this happened. (Some property remained in her cell, which had not been released by the police.) The prison also arranged for her family to visit Peterborough, where a memorial service was held, and they had the opportunity to visit A wing and speak with some of her friends.

63. The Director of HMP Peterborough and one of his senior staff attended the funeral. The woman's son was also escorted to the funeral.

64. On 11 March, the woman's probation officer, received a fax confirming that the Parole Board had decided that the woman should be released on licence on the basis of the recommendations made by him.

## ISSUES

### The woman's recall on 5 February 2008

65. The proposal to recall her on 5 February was taken after a consultation between her probation officer and his managers with the final decision being made by the ERR Section. They took account of the fact that she had received a Suspended Sentence and Supervision Order (as well as a final warning from the Assistant Chief Officer for a similar offence in February). Her probation officer said that the proposal was also based on the increased risk of her committing further offences and possibly harming herself. Although the purpose of my office is to investigate the circumstances of the woman's death, I take this opportunity to comment that I believe the probation officer's recommendation of recall was appropriate in the circumstances.

66. The woman's partner told the investigator that he felt that the decision had been made too quickly. He felt that her probation officer should have waited to see what action the police were going to take. It was clear during the investigation that the woman had made significant progress during her period of licence and that the decision to recall had not been taken lightly. However, following her release on police bail she had contacted her probation officer and admitted the offence. Her probation officer became aware that she had been bailed and that there was a strong possibility that she would be formally charged.

67. Despite the decision to recall the woman, her probation officer recommended to the Parole Board that the woman could be released on licence. He considered the progress she had made could be better continued in the community. The Parole Board agreed with the original decision to recall her to custody, but accepted the recommendation and, on 12 March, ordered that the woman be released. Unfortunately, by the time this decision was communicated, she had already died.

68. The woman's partner also told the investigator that he felt that the recall to prison was directly related to her death. I would like to reassure him that although it caused the woman some distress, there is no evidence to suggest that it was in any way linked to her death.

    *The woman's family responded and said that whilst this may not have been influential in relation to her death it did cause her extreme anxiety. The family ask whether her probation officer had any other option other than to refer the woman to the ERRS.*

    *In my opinion, the probation officer was duty bound due to the woman's earlier offending to report the new offences to the ERRS. When ERRS made their decision it would have been based on all the information supplied to them, including her previous history. Despite the recall, the probation officer was instrumental in supporting the woman's re-release.*

**The woman's request to detoxify from methadone and her access to medication**

69. On her reception into custody, medical staff recorded all the medication the woman had brought in with her. This is recorded as being methadone 40mls daily, diazepam 5mg and tramadol 150mg. The doctor arranged for the methadone to be given on a maintenance programme of 40mls a day. The diazepam was issued on a gradual detox from 10 to 4mg over a four week period and her tramadol was stopped. During this initial consultation, there is no indication that the woman asked to be taken off her methadone.

*In response to the draft report, the woman's family asked whether diazepam was the most appropriate medication for her to be prescribed given her history of drug addiction and that diazepam is an addictive drug. Also the family were concerned that there was no mention of the process for monitoring someone who might be withdrawing from diazepam and asked whether the withdrawal programme was too quick given that she was distressed.*

*I am unable to confirm whether diazepam was the most appropriate medication for her, but I am aware of its extensive use for methadone users as part of maintenance programmes. The reason the woman was placed on a gradual reduction programme was to prevent her from becoming dependent. The detox was also gradual to minimise the affects of diazepam withdrawal. The detoxification nurse would closely monitor any detox programme.*

70. The detoxification nurse at Peterborough, saw the woman but the entry in the medical record is undated. The detox nurse recorded that the woman had expressed a wish to reduce her methadone, but the nurse was concerned as the woman used the drug for pain control. The detox nurse discussed her concerns with both the woman and the prison doctor. The woman was aware that a decision had been taken to refer her to the pain management clinic at the local hospital before any reduction in her methadone would be made. At the time of the woman's death, the appointment had not been received.

71. The woman's partner told the investigator that the woman felt that her concerns about her healthcare were not being taken seriously. I am aware that she had submitted a request and complaint form on 18 February regarding her medication. The Clinical Lead Nurse responded to the complaint and told her to make an appointment to discuss her concerns. When the investigator spoke to the Clinical Lead Nurse, she confirmed that she had spoken with the woman about medication and would see her regularly in the clinic for blood tests. She also said that she had discussed the woman with the detoxification nurse and that she was aware that a referral had been made to the pain clinic.

72. The woman's partner was also concerned that the woman had been prescribed diclofenac, an anti-inflammatory medicine. He said that, as an asthmatic, this medication could be dangerous for the woman and also caused her concern. The diclofenac had been prescribed on 25 February after the woman was seen by the doctor for swelling in her ankles. The doctor recorded in the medical

record that he had advised her regarding her asthma. The clinical reviewer also supports this and says, ”it is a demonstration of good practice for the doctor to have mentioned the possibility of her asthma being affected, and there is no mention in the records that her asthma was adversely affected”.

73. I am satisfied that the woman’s health needs were appropriately addressed, but make the following recommendation regarding the recording of medical information.

**The Director and Head of Healthcare should remind all clinical staff of their obligations to comply with the rules regarding record keeping set out in the relevant Nursing and Midwifery Council Guidelines.**

**Medical Response**

74. The Clinical Lead Nurse said during her interview that she felt that the woman “had gone” (meaning that she thought that she had already died) when she arrived at her cell. Despite this nursing staff and officers continued in their attempts to revive her until the arrival of the paramedics. I am aware that this may have been traumatic for some of the staff involved and the first time that they had been called upon to respond to what turned out to be a death in custody. I acknowledge the professionalism shown by the staff involved and ask the Director of Peterborough to make those staff aware of my comments.

## CONCLUSION

75. The woman had been making significant progress prior to her recall and it was with clear regret that her supervising officer made the proposal to recall her to prison. Despite her initial and understandable upset at her recall, she continued to remain positive. Her goal was to remain free of illicit drugs and ultimately stop taking methadone. The woman's death came at a time when she appeared to have found stability and was making plans for her future, something she had not previously been motivated to do.

76. The pathologist has attributed the woman's death to a combination of the prescribed medication that she had been taking, namely methadone and diazepam. In his report, he points out that the levels in her system were in keeping with her prescribed doses. This indicates that her death was not intentional. However, he gives no reason why it had a fatal effect. I am mindful that this may leave her family with unanswered questions, which I hope will be further investigated during the inquest process.

77. Since the issuing of the draft report, the investigator has attempted to gain further information on how benzodiazepines contribute to fatal methadone toxicity. The investigator found that there were recent studies that showed benzodiazepines may contribute to deaths from methadone toxicity by increasing upper airways obstruction. The study referred to by the investigator also said that 'benzodiazepines are more likely to contribute to fatal methadone toxicity in newly admitted maintenance patients and those taking methadone tablets for pain relief'.

**RECOMMENDATION**

**The Director and Head of Healthcare should remind all clinical staff of their obligations to comply with the rules regarding record keeping set out in the relevant Nursing and Midwifery Council Guidelines.**

*The Prison Service accepted this recommendation and said:*

> *'This has been placed as a standing agenda item on team briefings and Notices to Staff to be issued'*

*The target date for completion of this is given as September 2008.*