PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

Investigation into the circumstances surrounding the death of a woman at HMP & YOI Bronzefield in May 2010

Report by the Prisons and Probation Ombudsman for England and Wales

July 2013

This is the report into the circumstances of the death of a woman. She died in HMP Bronzefield in May 2010, during her first night in the prison. A post mortem and toxicology tests found that she died as a result of mixed drug poisoning. She was 30 years old. I offer my condolences to her family and friends.

The investigation was carried out by an investigator. A clinical reviewer conducted a review of the woman's clinical care in custody. Bronzefield prison co-operated with the investigation. The investigation had to await completion of the police inquiry and toxicology report and I regret the consequent delay to the report.

The clinical reviewer concludes that the medication prescribed to the woman on reception was not a good combination and that, had she not been prescribed them all, her death would have been less likely. However, she was also found to have smuggled some illicit drugs into prison and appears to have taken some of these, including codeine, as well as her prescribed medication. A toxicologist report found that the level of codeine concentration in her blood was approaching those found where death had been attributed to codeine alone.

Information from the police that the woman was concealing drugs on her person appears not to have been acted on. The difficulties of monitoring women who are suspected of concealing drugs internally is a problem for prisons but I consider that there should have been more consideration of how to manage the situation.

The woman was unwell when she arrived on the first night houseblock, yet staff did not refer her to healthcare nor make any record about this. She was not monitored at all by healthcare staff or officers during the night as I would have expected to happen for a woman with substance use problems on her first night in prison. When she was found, there was a delay in staff attending and entering her cell. While this would not have affected the outcome for her, the investigation has identified a need for more responsive emergency procedures.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **July 2013**

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SUMMARY

1. The woman was arrested at her home in Brighton on 5 May 2010 and taken into police custody. She had a history of illicit drug use, and the police suspected that she had secreted some drugs. While she was in the police station she was under constant supervision. She appeared in court the following day and was remanded to HMP Bronzefield where she arrived about 4.30pm. The papers that accompanied her noted that she had been on constant watch in police custody and that she was suspected of being in possession of drugs.

2. The woman had been in Bronzefield before. She went through reception procedures and was identified as requiring treatment for her substance use dependency. She saw a doctor in reception and they discussed her health and her drug use. He prescribed a range of medications for her various problems. She went through the usual searching procedures including a body orifice scan which detects concealed metal objects. Nothing illicit was found.

3. The reception process took some time and the woman did not leave the reception area until 8.20pm. She was allocated to houseblock one and vomited when she arrived there. She was not referred to medical staff, but taken to her cell. She remained there until just before 10.00pm, when she told staff that she had not received her prescribed methadone. She was then taken from her cell to see a nurse, who gave her the prescribed dose and she returned to her cell. No further observations were made of her that night.

4. At approximately 4.15am a member of staff patrolling the houseblock looked through the observation panel on the woman's door. He thought that she was asleep, but was unable to see any movement so he tried to attract her attention. When this was unsuccessful, he radioed for medical assistance. There was a problem with the radio signal strength, and healthcare staff were initially unsure what the nature of the emergency was. After a slight delay in entering the cell, an emergency ambulance was called and staff attempted to resuscitate her. Sadly, this was unsuccessful and at 4.48am paramedics confirmed that she had died.

5. After the woman died, a small plastic container was found concealed in her underwear. There were tablets in the container, which were later found to be various drugs including morphine, codeine, buprenorphine, and mirtazepine. The clinical reviewer considers that the combination of drugs prescribed to her in reception was outside usual clinical guidelines. In addition it appears that she had taken drugs that she had smuggled into prison and the mixture of these with her prescribed drugs was toxic.

6. We make eight recommendations concerning, search procedures, prescribing policy, referring unwell prisoners to healthcare, appropriate observation of detoxifying prisoners, staff responsibilities when a prisoner is found in a collapsed state, information given to families, record keeping and equipment checks, and appropriate debrief for staff.

THE INVESTIGATION PROCESS

7. This office was informed of the woman's death on 8 May 2010. The investigator subsequently issued notices to staff and prisoners at HMP Bronzefield informing them of the investigation and asking anyone who had relevant information to contact him. No one came forward. He examined her prison records, including the court escort papers, medical records and statements made by staff.

8. During the investigation the investigator visited Bronzefield and spoke to staff and prisoners who came into contact with the woman during her short time there. He formally interviewed seven members of staff. Six of these interviews were recorded. A note was produced of the seventh interview. He also spoke to members of the Independent Monitoring Board and made himself available to speak to the Prison Service Union, although they did not take up the invitation.

9. The investigator liaised with the police officer in charge of investigating the woman's death. He also spoke to the Independent Police Complaints Commission who was considering allegations she had made at the time of her arrest.

10. A clinical reviewer was asked to review the woman's clinical care. The investigator discussed aspects of her treatment both with healthcare staff at Bronzefield and with the clinical reviewer. He also discussed drug prescribing regimes with the Clinical Substance Misuse Lead in the Offender Health section of the Department of Health.

11. There were some complex issues over the drugs in the woman's system when she died. This led to further toxicology reports being requested. Once these reports were available, the police and Crown Prosecution Service decided to carry out further investigations. In accordance with our agreement with the police, while these were underway this office's investigation had to be suspended. This has caused a significant delay in issuing this report. No charges have been brought.

12. The investigator contacted Her Majesty's Coroner to inform him of the investigation and request a copy of the post mortem report. He remained in regular contact with the Coroner's office through the investigation. This report will be sent to the Coroner to assist in his enquiries.

13. One of this office's Family Liaison Officers (FLOs) contacted the woman's mother, her next of kin. She explained the investigation process and invited her and her family to ask any questions or raise any issues for consideration. The family raised the following issues:

    - The woman had been on constant watch in police custody because of suspicions that she was hiding drugs. Her family were aware that information about this accompanied her to prison yet, once she arrived in prison, she was not subject to observation.

- She was sick when she arrived on the wing yet was put in a cell on her own and not referred to a doctor.

- The family wanted to know whether there was a doctor in the prison when she first arrived, what medication she was prescribed and whether it was appropriate.

- The family was concerned that they had been given different information at different times from prison staff about whether she saw a doctor, the time she was last seen alive, the time she was found and whether she had been sick in her cell. They wanted to know what actually happened.

- The family were concerned about the general standard of liaison with the prison and described meetings with prison staff as uncomfortable. They said that not all of her property had been returned.

- The family were shocked at how dirty her cell was when they visited and wanted to know whether she had been offered a shower on arrival and whether she was provided with a towel and clean clothing.

- The family wanted to know whether a plastic container was found on her and, if so, what was inside it.

14. The investigator raised some issues about the woman's property with the prison on her family's behalf. The other issues are addressed in this report in so far as they could be clarified.

15. The woman's family received copies of the draft report as part of the consultation period. Comprehensive and substantial written representations were provided by the family. The family remained unhappy with a number of issues identified in the findings of the investigation. We have sought to address, clarify and provide further information where appropriate to the points raised. This was provided by way of separate correspondence.

HMP & YOI BRONZEFIELD

16. HMP Bronzefield is a modern prison for women privately run by Sodexo Justice Services which opened in June 2004. It performs the function of a local prison, accepting prisoners directly from the courts. Most women are on remand or serving short sentences although it also holds longer-term women prisoners including those serving life sentences. Bronzefield holds up to 527 women prisoners and has four main residential units. Primary healthcare is provided by Sodexo Justice Services, with an in-patient unit for up to 18 women.

Body Orifice Security Scanner (BOSS) chairs

17. Women prisoners arriving in Bronzefield are scanned on the Body Orifice Security Scanner, known as a BOSS chair. The BOSS chair is a fast, non-intrusive scanning system designed to detect objects concealed inside a prisoner's body or clothing. The purpose is to detect small weapons, mobile phones and any other concealed metal objects. It will not detect anything non-metallic.

Integrated Drug Treatment System (IDTS)

18. The integrated drug treatment system is a joint service of the Home Office, Department of Health, Ministry of Justice and the National Offender Management Service (NOMS). The IDTS in prisons aims to increase the volume of substance misuse treatment available to prisoners with a particular emphasis on early custody, improving the integration between clinical and other drugs services, and reinforcing continuity of care from the community into prison, between prisons and on release into the community. Key elements are to provide better treatment by offering a range of effective needs-based interventions, improved clinical management with the provision of opioid stabilisation and a greater number of maintenance prescriptions where appropriate and better targeting of interventions to match individual needs.

Previous deaths in Bronzefield

19. This was the third death at HMP Bronzefield since this office took over responsibility for investigations into deaths in prison custody in 2004. In addition, we have conducted an investigation into the death of a woman who had been released from Bronzefield the day before she died. There have been a further two deaths at the prison since the woman died. One of these deaths involves similar issues to those in this report, but the investigation is ongoing at this time.

20. In a previous report, the office made a recommendation that, when medication is being prescribed without the supporting evidence of a prescription from the community general practitioner, every attempt must be made to determine the correct dosage required.

Her Majesty's Inspectorate of Prisons (HMIP)

21. The most recent inspection report published by Her Majesty's Inspectorate of Prisons was that following an unannounced inspection in October 2010, just five months after the woman's death.

22. Inspectors found that safety in the prison was supported by generally positive relationships and a decent environment, and women had good access to the approachable and supportive safer custody team. Reception was described as bright and clean and most women said they were treated well there but some said reception officers were unwelcoming. The majority of women in the Inspectorate's survey said they were not offered the opportunity of a shower in reception when they arrived. There were some concerns about clinical management for substance users and the Integrated Drug Treatment System was not fully implemented or staffed. First night prescribing had been introduced but there was not always a doctor on duty in reception at the appropriate time. Only one of the seven doctors had completed specialist training. However, illegal drug use appeared relatively low.

23. The inspection team found that the women were very negative about the quality of health services and had many justified complaints. Although most of the basic provision was in place, the delivery was said to be compromised by inadequate nursing and administrative staffing levels.

Independent Monitoring Board

24. Every prison in England and Wales has an Independent Monitoring Board (IMB), made up from volunteers from the local community, responsible for monitoring day-to-day life in the prison to help ensure that proper standards of care and decency are maintained. In their annual report for 2009 – 2010, which covered the time the woman was there, the IMB noted that the introduction of the Integrated Drug Treatment System (IDTS) had suffered from delays. The IMB described primary healthcare provision at Bronzefield as "shockingly poor". In their more recent report for the period August 2010 to July 2011 the IMB reported considerable improvements in health services. The Board reported that the IDTS had finally gone live in April 2011. They had continuing concerns about the supervision of methadone dispensing.

KEY EVENTS

25. The woman was born in 1979. She had three children. She had a history of substance use problems and a number of previous convictions dating back to when she was 17 years old. She had been in prison before, including three occasions in HMP Bronzefield. The first two were for only a matter of days and the last occasion was in the summer of 2009, when she was there for just over five weeks.

26. The woman was arrested on Thursday 6 May 2010 at her home and taken into police custody. The arrest happened after a struggle and both she and a police officer complained of being assaulted. The police medical form notes that she was showing signs of withdrawing from medication and was noted to be shaking. She was allowed to take diazepam (a drug used to treat anxiety), which she had in her possession. While in police custody, she took 5mg of diazepam and two paracetamol tablets at 1.20pm, then 10mg of diazepam and 45mg of mirtazapine (an anti-depressant) at 10.09pm.

27. The woman was charged with possession of class A drugs and assaulting a police officer. She was listed to appear in court on Friday 7 May. At 1.25am she was given two 30mg doses of dihydrocodeine (a strong painkiller). At 7.40am, she was given 10mg of diazepam. At 8.59am she was given two 30mg doses of dihydrocodeine. She was then searched and taken to court, where she arrived at 9.45am.

28. At her court appearance the woman was remanded into custody and left the court at 2.55pm for HMP Bronzefield. Records show that escort staff checked on her four times on the journey at 20 minute intervals. No problems were reported. The escort vehicle arrived at Bronzefield at 4.23pm. When prisoners are moved between locations, including between court and prison, they are accompanied by a Person Escort Record (PER). Her PER contained warnings that she had been violent when taken into custody and that she was suspected of having drugs in her possession. The form noted that she had been watched constantly in police custody because of the suspicion that she had secreted drugs. In the section covering health risks, the PER referred to epilepsy, asthma, pleurisy, alcoholism and methadone use. She was also noted to suffer from depression and to have mental health problems, for which she was receiving medication. She left the vehicle at 4.33pm and a Prison Custody Officer (PCO) signed the PER to accept her into prison custody at 4.35pm.

29. The prison record created on the woman's arrival does not note any of the warnings from the PER. The prison log shows that she was scanned on the BOSS chair at 5.00pm. No follow-up action was necessary.

30. The woman was then seen by a nurse for health screening. The first reception health screening (carried out to identify any immediate physical or mental health needs) notes that she complained of pain in both wrists, as well as pain in her right shoulder, which she said were a result of having been restrained by the police when arrested. The form shows that a nurse had examined her injuries while she was in police custody. A urine test gave positive readings for heroin

and benzodiazepine (sedative). She said that she had no reason to believe she was pregnant. She was assessed as fit to undertake work in prison, but the form noted that she was to undergo detoxification for drugs and alcohol. As her urine test showed recent drug usage, she was referred to the doctor on duty in reception and went to wait in a communal area.

31. Security information suggested that while in one of the communal waiting areas, another prisoner asked the woman for drugs, believing that she had some in her possession. However, another prisoner's account contradicts this and suggests that this did not happen. There is no further information to indicate whether this alleged incident occurred.

32. The doctor on duty that afternoon was one of Bronzefield's Integrated Drug Treatment System (IDTS) doctors. Unless they have acute medical problems, newly arrived prisoners are referred to the reception doctor only if they require drug treatment. He explained in interview that when he saw prisoners in reception he did not have access to the PER or any previous prison files. He therefore had no knowledge that the police suspected that the woman had secreted drugs. His role was to assess the prisoner's clinical needs and prescribe medication as appropriate.

33. The doctor and the woman discussed her medical history, including a recent hospital admission. She said she had been suffering from pneumonia and pleurisy. She said that she was currently prescribed diazepam (a sedative), mirtazepine (an antidepressant), codeine phosphate (an opium-based painkiller), a salbutamol inhaler (often used by those with asthma) and zopiclone (a drug to aid sleeping). She had all these medications with her, in labelled bottles, which had been prescribed recently.

34. The woman told the doctor about her illegal drug usage. She said that she had been buying tegratol (which is an anti-epilepsy drug) and rivotril (a sedative, like valium or diazepam). She also said that she was on a daily prescription of methadone (an opiate substitute) and had also been injecting heroin. He said that he had to assess her drug usage as best he could without access to her previous medical records. He took into account her urine sample which was positive for heroin and benzodiazepine and negative for methadone and cocaine. He considered that she gave a credible account of the drugs and the amounts she used. She also reported significant alcohol consumption.

35. The doctor said that he did not have any reason to contact the woman's own doctor at this stage. He prescribed mirtazepine, chlordiazepoxide (used in relation to alcohol detoxification), diazepam, zopiclone, and promethazine (a sedative). She would also continue to receive methadone. The drugs were not issued for her to keep in her possession but to be dispensed according to the prescribed dosage. He did not re-prescribe codeine phosphate, as he said he would first need to check the prescription with her own doctor. As she came into prison on a Friday, the intention was that the prison healthcare team would contact her GP the following Monday morning to check her prescribed medication.

36. The doctor assessed the woman, which included checking her pulse rate, blood pressure and carrying out a chest examination because she said she had recently had pleurisy. He said she seemed anxious about not receiving her medication and did not seem to be intoxicated. He discussed her prescriptions with her and said she seemed calmer after speaking to him. He said he had no particular concerns about her and because she did not seem to be unwell there was no reason to admit her as an in-patient to the healthcare unit.

37. A cell-sharing risk assessment (CSRA) is completed for all new prisoners, to check whether there is any risk to other prisoners who might share a cell with them. The woman's CRSA did not refer to the warnings on the PER form, indicated no concerns and assessed her as low risk. She was issued with a night pack, which contained pyjamas, underwear, socks, toiletries, toothpaste, toothbrush, soap, deodorant and shampoo. Bronzefield's reception procedures require that, before leaving reception, every prisoner is offered a free five minute telephone call and a shower. A record should be kept if the woman is unable to make the call. The telephone audit sheet for 7 May shows that she did not make any calls and the form is marked "will try tomorrow". There is no indication whether she was offered a shower. Reception staff said that they were certain that this happens for every prisoner, but we note that the 2010 inspection found that the majority of women prisoners surveyed said they were not offered a shower in reception.

38. The reception process at Bronzefield can take a long time and, on that Friday afternoon, there were 43 women prisoners booked in, 21 of whom were new to the prison rather than returning from court. The woman remained in the reception area until shortly before 8.20pm, almost four hours after she arrived. At that time she went to houseblock one, the first night centre.

39. Prison Custody Officer (PCO) A was on duty in houseblock one when the woman and the other new prisoners arrived from reception. The PCO said that, from her experience, she could see that she was withdrawing from drugs. The PCO knew her from a previous stay at Bronzefield and could see that she did not look well. The PCO said she checked her papers which indicated that she was on a detoxification regime.

40. While in the central area of the houseblock, waiting to be taken to her room, the woman suddenly felt nauseous. Seeing that she looked as if she was about to be sick, PCO A directed her to a sink in the cleaners' cupboard which was nearby. (Although called a cupboard, it is actually a medium-sized room containing all the cleaning equipment for the houseblock.) She hurried to the sink and vomited. The officer who had escorted the prisoners from reception told the PCO that she had not yet had her methadone.

41. PCO A said the woman said she felt better after being sick and agreed she was able to walk to her cell. She told the PCO that she had not yet received her methadone and the PCO told her that the nurses were aware of this and she would get it later. Two PCOs then took her to her cell. The PCO said in interview that she thought the woman still looked quite unwell at this point. No

notes were made in the wing observation book to let other officers know that she had been sick and healthcare were not alerted.

42. Most of the cells at Bronzefield are single occupancy and the woman was given one of these on the first floor of D Spur in houseblock one. Bronzefield's reception procedures state that the cells should be made up ready for the new prisoners and all the necessary items should be available. The cells should be clean, with fresh bedding. However, on arriving at the cell, PCO A saw that there was no bedding ready for her. Otherwise, she recalled that the cell was clean and suitable. She arranged for some fresh bedding for her to be collected from the laundry.

43. The wing observation book shows that, at 9.47pm, the woman pressed the call bell in her cell and asked for her prescription of methadone. PCO B escorted her from her cell to the pharmacy on the ground floor where Nurse A was preparing night-time medications. The nurse checked that the prescription was correct and gave her the methadone.

44. PCO B did not recall the nurse asking the woman any questions, but the nurse said that she made a visual check to ensure that she was alert (if prisoners appear drowsy, then the nurses do not dispense methadone) and checked that she felt okay. The nurse gave her 10ml of methadone and said she declined the offer of water with it. The nurse did not know that she had vomited earlier in the evening. However she told the investigator that, if she had known, it would not necessarily have precluded her from dispensing the methadone provided she felt all right at the time. The nurse did not think that she appeared to be intoxicated. Her medical file shows that the methadone was dispensed at 9.50pm. She took the methadone and the PCO took her back to her cell.

45. PCO B said that, at that time, the woman seemed fine. She was fully awake, alert and walked normally to and from her cell with no signs of any problems. On return to her cell, she mentioned that the aerial on her television was not working. The PCO said he would attend to it in the morning. While they spoke, he said she got into the bed and pulled the duvet over her.

46. Although the woman was prescribed medication for alcohol withdrawal and was on a methadone regime on her first night in the prison she was not checked during the night, as she was not considered at risk of harming herself. The next time that a member of prison staff saw her was when PCO C was distributing material to cells for prisoners to write letters. He reached her room at approximately 4.20am on 8 May. He looked through the observation panel, and could see her lying on her right side on the floor by the bed. He thought that she was asleep but, as he was unable to see her face fully, he could not confirm this and could not see her breathing. He watched her for a minute or so but, as he was unsure, he radioed for a nurse to attend and give a second opinion.

47. Nurse A was the emergency medical responder in the prison that night and carried a radio with the call sign Hotel Two. At approximately 4.20am on 8 May, when the call came in over the radio, she was in houseblock one with another

nurse. PCO C asked for Hotel Two to attend, but the radio message was not fully audible. The nurses heard him repeat the message more than once, but it remained unclear. They therefore went to the office on houseblock one, but PCO B who was there did not know exactly where PCO C was. Another message then came through from PCO C to say that he was on D spur (where the woman's cell was).

48. The night orderly officer (NOO) in charge of the operation of the prison that night was a Senior Prison Custody Officer (SPCO). He had heard the radio messages and radioed Nurse A to ask if there was a problem. She said that she would update him as soon as she knew what the call was about. The nurse them went to D spur and joined PCO C outside the woman's cell. There is no record of the time she arrived.

49. Nurse A looked through the observation panel and saw the woman still lying on the floor. When interviewed, the nurse said that she immediately formed the impression that she had died. Her face was ashen grey in colour and, when she called to her, she did not respond. The nurse could not detect any movement to indicate breathing. She ran down the stairs and, as she passed her, told Nurse B that she was going to get the resuscitation equipment from the pharmacy on the ground floor. Nurse B immediately went to the cell.

50. During the night, staff on residential units have keys in sealed pouches which should only be broken for use in an emergency. As Nurse B arrived at the cell, PCO C was on the radio to the NOO asking for permission to break the seal on his pouch and enter the cell. The NOO said that he was on his way. The nurse looked through the observation panel, saw the woman's pallor, and could see no signs of breathing. She told the PCO that she needed to go inside immediately so he broke the seal on his key pouch and they went into the cell.

51. PCO C tried to turn the woman over, and her body was stiff. Although the woman's family initially understood that she was found to have vomited neither the nurse nor the officer mentioned this in their statements or at interview. The PCO radioed to the control room to say that an emergency ambulance was required. Records show that the ambulance was called at 4.28am. Nurse B checked her but was unable to gain a response. She removed some of her clothing to facilitate resuscitation and then started cardio pulmonary resuscitation (CPR)[1].

52. At this point, Nurse A arrived with the resuscitation equipment and an oxygen cylinder. She applied a defibrillator (a machine that analyses heart rhythm and advises whether to apply an electrical impulse to the heart, which can rectify a failing rhythm) to the woman, while the other nurse administered oxygen. The defibrillator did not detect any shockable rhythm in her heart. By this point, other staff had responded to the emergency. Nurse B and a SPCO continued the CPR.

[1] Cardio pulmonary resuscitation is a technique whereby oxygen is pumped around the body using a combination of chest compressions and rescue breaths.

53. As soon as the ambulance had been called, two members of staff went to the gate to ensure that it could be taken through the prison with minimal delay. The ambulance arrived at 4.40am. The nurses and SPCO continued to attempt to resuscitate the woman until the ambulance crew arrived. Nurse B briefed the paramedics, and they instructed the staff to stop their attempts at resuscitation. At 4.48am, the paramedics confirmed that she had died.

54. A "hot" debrief was held by a manager.[2] Staff were reminded of the support that was available to them, although healthcare staff were not included in the meeting. The post incident care team (PICT) was called to support staff who needed it. Nursing staff said that support was offered to them if they wished.

55. As is always the case when a death occurs in custody, the police attended. They arrived at 5.10am and a note on the prison record says that the "… police checking the body of the woman found unauthorised article strapped above pelvis area". The investigating police officer later confirmed that a small plastic container had been found inside her underwear. It contained tablets, which were sent by the police for analysis.

56. The other prisoners on the wing were advised of the woman's death by the duty manager when they were unlocked in the morning. All the women being monitored as at risk of harming themselves were assessed to check whether they needed additional support.

57. The prison chaplaincy team organised a service for the woman on houseblock one that afternoon. Additional services took place in the chapel on the Sunday, the following day. When the prisoners were locked into their cells after lunch, the wing manager altered the normal procedures to allow the women to stay in a cell with another prisoner in case they needed extra support.

58. The Director held a further debrief for staff the following afternoon. Staff who had had individual dealings with the woman were allocated an individual PICT member. Support was made available to all the other staff. The care team also emailed all managers asking them to be alert to any staff who might be affected. Notices were posted to staff and prisoners informing them of her death and advising them where to get support if required. An employment assistance programme, offering confidential counselling and advice, was also subsequently engaged to provide support to staff.

59. The woman's next of kin was her mother. The Director and one of the chaplains left the prison at 8.00am to go to her home in Brighton to inform her of her daughter's death. The prison appointed a family liaison officer and an assistant.

[2] Hot debriefs should be held as soon as possible after a death in custody to ensure that staff have an opportunity to discuss any issues arising and provide mutual support.

60. In line with national guidance, the prison offered to contribute towards the woman's funeral. Representatives of the prison attended the funeral, with the permission of the family.

61. The woman's family were unhappy with the family liaison arrangements. They said that they found the meetings uncomfortable and at different times were given conflicting information about details of what had happened. We understand that at an early stage the prison made an effort to provide as much information as possible but some of the details were slightly incorrect which caused some distrust.

Post Mortem and toxicology

62. A post mortem was carried out by a Home Office registered forensic pathologist on 12 May 2010.

63. The drugs found in the container on the woman were found to be:

- 11 tablets of a pharmaceutical preparation containing buprenorphine (an opiate substitute used in the treatment of heroin addiction)
- nine tablets (in total – eight tablets plus fragments) of a pharmaceutical preparation containing mirtazepine
- three tablets of a pharmaceutical preparation containing morphine
- 11 tablets of a pharmaceutical preparation containing codeine
- two further tablets of a pharmaceutical preparation containing codeine.

64. Toxicology reports indicated that, in addition to the medication the woman had been prescribed, she was likely to have taken some drugs of the type found in the container which was found by police. The pathologist concluded that death resulted from mixed drug poisoning.

ISSUES

Bringing drugs into Bronzefield

65. One of the woman's friends at Bronzefield told the investigator that her cellmate, like the woman, lived in the Brighton area. The cellmate was also friendly with the woman and said that she had previously told her that if she had to go back into prison she was going to be "plugged up", meaning with a quantity of drugs concealed inside her body.

66. The woman's family told the investigator that the police had shown them documents which indicated that, while she was in police custody she was watched constantly, with a member of staff stationed permanently outside her cell. They said that the person undertaking these duties was relieved every three hours. These papers were not amongst those passed to the prison, but her PER does note that she was on a constant watch in police custody because of the suspicion that she had secreted drugs.

67. Women prisoners are no longer routinely strip searched on arrival at prison. The practice was stopped because it distressed many women, particularly those with mental health problems and the high proportion of women prisoners who had been sexually abused. It was also found to be ineffective as, given their anatomy, women can conceal items internally for a long time. Women can still be subject to a full or strip search if there is intelligence or reasonable suspicion that an item is being concealed which might be revealed by the search.

68. On arrival at Bronzefield, the woman was given a routine rub-down search and scanned using the BOSS chair to detect any hidden metal items. Although the PER which accompanied her to Bronzefield indicated that she was suspected of having drugs concealed and that she had been watched constantly in police custody as a result, there is no indication that this information was considered when she arrived at the prison to determine whether a full search was necessary or that any other action should be taken. We accept that, had she been concealing the drugs internally, a strip or full search would not have detected them.

69. What to do in these circumstances is a dilemma for prison staff. Internal concealment of drugs is very hard to tackle, given the legal and moral constraints on intimate searches. We understand that the options are very limited, but it is a concern that no one seemed to have acted on the information from the police that the woman was concealing drugs. Women suspected of concealing drugs could be held apart from other prisoners for observation, either in the healthcare centre of the segregation unit, but that would not ensure that drugs held internally would be found. We do not think it is feasible or reasonable that women suspected of concealing drugs internally should be subject to constant supervision as happened in police custody, as that was for a very limited period. In any event women, could easily dispose of concealed drugs without the knowledge of prison staff, or hold them indefinitely.

70. Nevertheless, we do not consider that taking no action in the woman's case was reasonable. Someone should have considered whether a higher level of search was necessary. At the very least, someone should have discussed the intelligence with her and warned her of the dangers if she took additional drugs on top of those she had been prescribed. We understand that it is not uncommon for prisoners arriving at Bronzefield to be suspected of smuggling drugs into the prison yet there is no clear guidance to prison custody officers about what to do in such circumstances when the BOSS chair does not detect anything. Where there is intelligence that a woman might be hiding drugs, the prison must treat the warnings with appropriate significance.

The Director should ensure that any intelligence that a newly arrived woman prisoner is concealing drugs is identified and referred to managers to decide appropriate action in each individual case, and that prison custody officers are given clear guidance to this effect.

The woman's prescribed medication

71. The clinical reviewer judges that the drugs prescribed to the woman in reception were not a good combination. While he acknowledges that each individual dosage was within the recommended limit, a number of the drugs were likely to have interacted poorly and have had a sedative effect on her system. He considers that had fewer drugs with a sedative effect been prescribed to her then it would have reduced her risk of death. He did not consider that all the drugs prescribed were necessary.

72. In addition, the clinical reviewer says that he did not find any evidence that healthcare staff conducted a clinical examination for any signs of alcohol withdrawal. Without the woman having been examined, he does not consider that chlordiazepoxide, given for the symptoms of alcohol withdrawal, should have been prescribed. Similarly, the clinical reviewer would not expect symptomatic relief to be given to someone who was prescribed methadone, and so he does not consider that she should have been prescribed promethazine.

73. As stated, the dosages for each individual prescription were within recommended limits. The woman had a history of substance misuse, and she might have been expected to have had a higher than usual tolerance to particular types of drug. Nevertheless, the Head of Healthcare should consider the clinical reviewer's review, particularly in relation to the national guidelines, and the prescribing regime at Bronzefield.

The Head of Healthcare should ensure that the prescribing regime for drug and alcohol withdrawal and methadone maintenance is in line with national guidelines.

The woman's location and supervision

74. When the woman left the reception and arrived in houseblock one, she vomited in one of the rooms used to store cleaning materials. She was then taken to her cell, and was not referred to anyone from healthcare. Nothing was noted in

either her record or the wing observation book. It is possible that because both day and night shift staff were present they felt suitably informed and therefore did not update the written records. However up to date records are an important safeguard and significant incidents should always be included.

75. Prison staff at Bronzefield are very familiar with the symptoms of women prisoners withdrawing from drugs, particularly on houseblock one which takes new arrivals. PCO A has experience of seeing prisoners withdrawing from drugs and recognised the signs in the woman. She knew that she had not yet received her methadone prescription and suspected that if she referred her to a nurse, the nurse would have said that she had been sick because she was waiting for her medication.

76. There are no local instructions at Bronzefield advising officers what to do when prisoners are unwell. While prison custody officers undoubtedly develop experience and expertise looking after women who are withdrawing from drugs and become familiar with the signs, they do not have medical training. It is therefore important that when a woman prisoner is unwell, particularly when they are undergoing drug treatment, that prison staff document the incident and seek advice from healthcare staff. The investigator has been told that, since the woman's death, staff at Bronzefield now check women who are detoxifying from drugs every hour. They also check all new prisoners every two hours. These are important safeguards which we welcome, but it is also important that prison custody officers understand the need to refer prisoners with health problems to a healthcare professional.

The Director should ensure that all prison staff refer women prisoners who are unwell to a healthcare professional and document all incidents.

77. The woman was allocated a cell on the detoxification spur of houseblock one. In addition to her methadone treatment she had been prescribed chlordiazepoxide for alcohol withdrawal. The Department of Health's guidance on the Clinical Management of Drug Dependence in the Adult Prison Setting recommends (chapter 3, paragraph 3.1) that for prisoners with current or recent substance misuse:

> "Wherever possible, location should be in a unit that offers access to unrestricted observation at all times 24 hours a day by healthcare staff trained in substance misuse. This observation is best made through open healthcare hatches (HM Prison Service 2000). Healthcare hatches are recommended for initial accommodation for prisoners as they can afford a level of observation that includes visual, oral, auditory, olfactory and tactile communication and monitoring."

78. We are particularly concerned that the woman was not subject to regular monitoring because of her alcohol withdrawal as well as her opiate withdrawal. Further guidance on IDTS, issued after her death, requires that clinical observations are recorded at least twice a day for those undergoing stabilisation. She was not monitored at all after arriving on houseblock one. This was a significant omission. The Head of Healthcare should consider the

current IDTS guidance (PSI 45/2010) and ensure that there are always appropriate arrangements in place for observing prisoners withdrawing from drugs and alcohol.

The Head of Healthcare should ensure there are appropriate arrangements for observing prisoners who may be withdrawing from drug use in line with the guidance contained in PSI 45/2010 Integrated Drug Treatment System.

The woman's cell

79. When the investigator first visited Bronzefield, he was told that a member of staff had said that the woman was put into a dirty cell. Her mother also said that the cell was not clean when she saw it.

80. The cell given to the woman had been vacated quickly to provide a space for her. The investigator was told that, while it might not have been cleaned as fully as procedures usually require, it had been cleared and the staff said that it was reasonably clean. It is not possible to say whether the cleanliness had deteriorated between her arrival and her mother's visit or what the condition of the cell was when she arrived. She was given fresh bedding, and she made no complaint about her cell, other than that her television aerial was not working.

Emergency response

81. The woman was found before the morning roll check by PCO C. He promptly put a call out across the radio network for a member of healthcare staff to come and assess her. He did not use an emergency call sign because at the time he was not sure that it was an emergency. Other staff were unable to hear him properly because the radio signal was too faint. Nurse A went to the cell quickly, but without any emergency equipment as she did not know what the problem was. It was only after speaking to the PCO and looking through the observation hatch that she went to collect the emergency equipment. We are surprised that the PCO and nurse did not enter the cell to assess her at this point. The nurse made an assessment based only on what she could see through the hatch.

82. As the prison was in night state, PCO C needed to open his sealed pouch before opening the woman's cell. There was some delay while he sought permission from the Night Orderly Officer, and he did not open the cell until this was requested by Nurse B, who attended while Nurse A was collecting the emergency equipment. We know that this was some eight minutes after the PCO first saw her, because an ambulance was called immediately staff entered the cell and this is recorded as 4.28am. It should not be necessary for prison staff to get permission from the Night Orderly Officer before entering a cell. The purpose of officers being supplied with sealed cell keys is so that they can enter cells immediately in an emergency provided they judge it is safe to do so. As he was joined quickly by Nurse A we can see no reason why they did not enter the cell at that stage to assess her and call an ambulance. While it appears

that at that stage she was dead, in other cases acting immediately can make a vital difference.

The Director should ensure that there are responsive emergency procedures and that all staff understand their responsibilities to act immediately when they find a woman prisoner in a state of collapse.

83. It is unsatisfactory that prison staff were not able to hear clearly the initial radio message asking for assistance. It is important that such equipment is tested regularly and is in good working order. Had healthcare staff received the full message they would have known were to go to immediately and what equipment to take. Again, we acknowledge that this is unlikely to have affected the outcome for the woman.

The Director should ensure that all radio equipment works correctly so that an effective response in an emergency is not compromised.

84. Once they entered her cell, staff appear to have made a concerted effort to resuscitate the woman. They called an ambulance immediately and continued with CPR until the ambulance team arrived and instructed them to stop.

85. It is unlikely that any of the delays we have identified during the incident would have made any difference to the outcome. Although staff worked hard to try to resuscitate the woman, it appears that she had already been dead for some time.

Family liaison

86. Liaising with the family of a prisoner who has died is a difficult undertaking and needs to be handled with sensitivity. Each family will react differently and will need different levels of support. The woman's family said that, after her death, they received conflicting information from the prison. It is not possible to establish exactly what happened at the time, but it is an essential part of a prison's liaison with families to ensure that any information provided is accurate.

The Director should ensure that liaison with bereaved families is handled sensitively and that any information provided is accurate.

Support for staff

87. Although a debrief was held for staff, healthcare staff were not included. National guidance states that a 'hot debrief' must be held immediately after all deaths in custody. It should be chaired by a senior staff member and should include all staff directly involved in the incident, including healthcare staff. Such a debrief is important in terms of providing staff with the opportunity to discuss what has happened, provide mutual support and the chance to discuss any issues or learning.

The Director should ensure that all staff, including healthcare, are included in the hot debrief following a death in custody.

CONCLUSION

88. The woman had long standing substance misuse problems and had been in Bronzefield previously. She arrived with a warning from the police that she might be secreting drugs. She was assessed in reception and prescribed a range of medication for substance misuse problems and other medical conditions.

89. A routine rub-down search and a metal detection search revealed nothing untoward. The intelligence that she was suspected of concealing drugs in her body does not appear to have been acted on and there was no further consideration of whether any special measures should be taken. The prison doctor was not told that she might have smuggled drugs and he assessed the woman on the basis of his own observations and what she told him. There was no discussion with her about the implications of taking additional drugs beyond what she had been prescribed.

90. On arrival in the houseblock, the woman was sick, but was not referred to a member of healthcare staff. After collecting her prescribed methadone that evening she remained alone in her cell. Although this was her first night in the prison, and she was likely to be experiencing some withdrawal symptoms from both drugs and alcohol for which she had been prescribed medication, there were no further observations of her during the night.

91. Early the next morning a prison custody officer on a routine task to deliver stationary to cells noticed that the woman was lying on the floor of her cell. He was unable to be sure that she was breathing and called for assistance which was slightly delayed by a poor radio signal. When the nurse arrived, neither the PCO nor the nurse considered an emergency entry to the cell at that stage, although the nurse left to get emergency equipment. Another nurse arrived and then the cell was opened. An ambulance was called and prison staff attempted to resuscitate her, but they were unable to do so.

92. A small plastic container with tablets was found on the woman's body inside her underwear. The tablets were later found to be illicit drugs, traces of which were found in her system together with the medication which she had been prescribed. The clinical reviewer's opinion is that the medications prescribed to her were not a good combination. He judges that, had she not been prescribed them all, it would have reduced the probability of her death. It is significant, though, that the toxicology reports indicate that she took some of the drugs which she smuggled into prison The clinical reviewer concludes that she is likely to have died from a combination of the various drugs prescribed to her, plus the drugs that she brought into prison with her.

RECOMMENDATIONS

1. The Director should ensure that any intelligence that a newly arrived woman prisoner is concealing drugs is identified and referred to managers to decide appropriate action in each individual case, and that prison custody officers are given clear guidance to this effect.

   The National Offender Management Service (NOMS) accepted this recommendation with the following comment:

   "We have now introduced a system whereby, on a prisoner entering Reception, it is the responsibility of the Senior Officer in charge of to carry out a number of checks, which includes the Prisoner Escort Record.

   However, clear guidance was in place at the time of the woman's death. It outlined the process that staff should follow when they suspect that items are concealed on a prisoner. The instructions are described in Local Operating Procedure 2.0. "

2. The Head of Healthcare should ensure that the prescribing regime for drug and alcohol withdrawal and methadone maintenance is in line with national guidelines.

   The National Offender Management Service (NOMS) accepted this recommendation with the following comment:

   "Bronzefield went live with IDTS on 31st March 2011, subsequent to the woman's death in May 2010. Since this date, the prescribing regime for drug and alcohol withdrawal and methadone maintenance is in line with national guidelines. "

3. The Director should ensure that all prison staff refer women prisoners who are unwell to a healthcare professional and document all incidents.

   The National Offender Management Service (NOMS) accepted this recommendation with the following comment:

   "The Early Days in Custody House block (where the woman died) now benefits from 24 hour nursing care at all times. There is also a Nurse Team Leader located on the House blocks.

   Staff are now able to contact the Nurse or Team Leader if they have concerns over the wellbeing of any prisoner. They would also log this contact in the House block Observation Book.

   In addition to this all prisoners have access to a triage nurse on a daily basis and are able to self-refer if necessary

   When prison staff suspect a woman is unwell they can:

- Refer to the Triage Nurse
- Refer to the house block Nurse who is dispensing medication
- Refer to Nurse Team Leader (Resident on the House block)
- Refer directly to Healthcare

All referrals are noted in the Prisoner record on NOMIS."

4. The Head of Healthcare should ensure there are appropriate arrangements for observing prisoners who may be withdrawing from drug use in line with the guidance contained in PSI 45/2010 Integrated Drug Treatment System.

   The National Offender Management Service (NOMS) accepted this recommendation with the following comment:

   "PSI 45/2010 was issued in September 2010 and the woman died in May 2010. This was prior to the instruction being issued.

   However, following the issue of PSI 45/2010, medication hatches have been installed into cell doors on HB1 providing adequate access for observation to be carried out during the night or during a patrol state."

5. The Director should ensure that there are responsive emergency procedures and that all staff understand their responsibilities to act immediately when they find a woman prisoner in a state of collapse.

   The National Offender Management Service (NOMS) accepted this recommendation with the following comment:

   "Emergency procedures are outlined within the Local Security Strategy which is available via the intranet.

   Additionally, all operational staff undergo training in this area.

   These procedures were in place at the time of the woman's death."

6. The Director should ensure that all radio equipment works correctly so that an effective response in an emergency is not compromised.

   The National Offender Management Service (NOMS) accepted this recommendation with the following comment:

   "Although unrelated to this investigation, the radio system at Bronzefield has subsequently been renewed. Currently, as was the case at the time of the incident, radio checks are carried out daily as well as net tests to establish that a satisfactory signal is in operation around the establishment.

   In the event of the Radio system failing there is a backup contingency in place."

7. The Director should ensure that liaison with bereaved families is handled sensitively and that any information provided is accurate.

   The National Offender Management Service (NOMS) accepted this recommendation with the following comment:

   "This recommendation is based upon interviews with the woman's family and has not been balanced with interviews with Bronzefield's Family Liaison Officers or interrogation of the Family Liaison Officer's Log. Combined, these describe that liaison with the bereaved family was handled sensitively and that the information provided was accurate."

8. The Director should ensure that all staff, including healthcare, are included in the hot debrief following a death in custody.

   The National Offender Management Service (NOMS) accepted this recommendation with the following comment:

   "The staff in question were invited to attend the Hot Debrief. However, they had been working a night shift and so requested to go home. Before being allowed to do so, they were all personally debriefed by the Deputy Director and appropriate support was given."