PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

Investigation into the death of a woman whilst in the custody of HMP Bronzefield in March 2011

Report by the Prisons and Probation Ombudsman for England and Wales

March 2013

This is a report into the death of a woman, who died at HMP Bronzefield in March 2011. I offer my condolences to her family and friends.

The investigation was carried out by one of my investigators. A clinical reviewer was commissioned to complete a review of the clinical care provided to the woman at Bronzefield. I apologise for the delay in issuing this report.

When the woman arrived at Bronzefield on 14 January 2011, she told staff that she was dependent on heroin and crack cocaine and had also been taking 60mls of methadone daily. A urine test indicated that she had used benzodiazepines but there was no record of a test for opiates. The next day she was prescribed medication for withdrawal from benzodiazepines and placed on a methadone maintenance programme to help counteract the symptoms of opiate withdrawal. On 7 March, the woman said she was suffering from a migraine and went back to bed after receiving her morning dose of methadone. At midday her cell mate raised the alarm when she found her unresponsive. Despite attempts to resuscitate her, the woman was pronounced dead when she arrived at hospital.

The post- mortem found that the cause of death was due to cardiomegaly (enlargement of the heart) and fatty degeneration of her liver, caused by obesity. Methadone toxicity was listed as a condition contributing to her death, but the toxicologist noted that the woman would have had significant tolerance to methadone which reduced the likelihood of methadone being involved as the cause of death.

The investigation found no record that a full drug screen was done to assess the woman's suitability for a methadone maintenance programme. However, it is possible that the reception urine test was positive for opiates but not recorded properly in the woman's medical notes as symptoms of opiate withdrawal were noted a week after her arrival, when the doctor raised the level of methadone. While the clinical reviewer concludes that the woman's care at Bronzefield was appropriate, timely and professional, I remain concerned that methadone was originally prescribed without a fully documented account of the reasons. There is also a need for all staff who work with drug users in prison to be trained to spot the common symptoms of methadone toxicity and drug-induced unconsciousness.

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
Prison and Probation Ombudsman **March 2013**

CONTENTS

SUMMARY

1. The woman was sentenced to three months and nine days imprisonment. This was not the first time she had been in prison and she was familiar with the regime at Bronzefield. When she arrived at Bronzefield on 14 January, she said that she had been using heroin, crack cocaine, methadone and Valium. The records indicate that she tested positive for a small amount of benzodiazepines (the group of drugs to which Valium belongs). The woman was prescribed valium, buscopan, paracetamol and kalms on her first night at Bronzefield.

2. On 15 January, the day after she arrived, she was prescribed medication for anxiety and methadone to treat the symptoms of withdrawal from heroin. There is no record that her urine was tested for opiates to support this decision. The woman was referred to the Care Assessment Referral and Advice service (CARATs). (The CARAT service works with prisoners to help with drug rehabilitation and to provide a continuous support system when a prisoner returns to the community.)

3. On 7 March 2011, the woman complained that she had a migraine headache. The wing officer advised her to get advice from the nurses when she collected her morning medication. The nurses dispensing medicines said she did not mention having a headache. Because she was unwell, she went back to rest in her cell rather than doing her job as a wing cleaner. The wing officer asked her cellmate to keep an eye on the woman and she and other women prisoners on the wing checked her throughout the morning, as they were concerned about her. At about midday, her cell mate found the woman unresponsive in her cell.

4. Her cellmate called for assistance and staff attended quickly. They attempted CPR and an ambulance was called. The nurse performing cardiopulmonary resuscitation (CPR) found some fragments of tablets on her person which were later identified as clonazepam. Half a white tablet was found in a matchbox in her cell which was later found to be a caffeine tablet.

5. The woman was taken to hospital by ambulance and CPR continued throughout the journey. An emergency medical team was waiting for the arrival of the ambulance at the hospital but she was pronounced dead when she arrived.

6. We make four recommendations about obtaining community medical records for prisoners, the need to record results of urine tests and reasons for prescribing methadone, staff awareness of the signs of methadone toxicity and emergency use of defibrillators.

THE INVESTIGATION PROCESS

7. The investigator visited HMP Bronzefield, on 11 March 2011 and saw the cell and wing where the woman lived. She interviewed the woman's cellmate and obtained copies of the woman's clinical and prison records. The investigator met the Director, the prison's family liaison officer and members of the Independent Monitoring Board.

8. The investigator contacted the Detective Sergeant who carried out the police investigation into the circumstances of the woman's death and the coroner's officer.

9. Notices were issued to staff and prisoners informing them of the investigation and inviting anyone who had relevant information to contact the investigator. No one came forward in response. The investigator returned to Bronzefield on 12 May 2011, to interview staff. She interviewed some prison staff by telephone and provided written questions for others who were unavailable for formal interview at the time. On 31 October 2012, she spoke to Dr A, who prescribed the woman with clonazepam and methadone on 15 January. The doctor no longer works at Bronzefield.

10. A clinical review was commissioned and was completed by the clinical reviewer. There was a long delay because the pathologist asked for a specialist toxicology report before completing the post-mortem report. This was received by the police and PPO investigation team late in 2011. A copy of the clinical reviewer's review is attached at annex 1. This was received on 8 August 2012, with further information received on 4 September 2012. The investigation had to await completion of the police enquiry, further toxicology reports and later the clinical review. We regret that this has led to the late issue of this report.

11. One of the Ombudsman's family liaison officers contacted the woman's family to explain the purpose and scope of the investigation and to give them an opportunity to identify issues they wished the investigator to consider. The Ombudsman's family liaison officer and investigator subsequently visited the woman's family at their home. The woman's family considered that the prison should have kept her safe from drugs and were concerned about the amount of drug abuse in the prison. Her family had the following questions:

    - Why did prison staff not check on the woman on the morning of her death?
    - At what time was the woman seen by staff that morning?
    - Why was the woman prescribed clonazepam?
    - Why did the nurse who gave the woman her medication that morning not check on her later?
    - Why was there no full reception drug screen recorded in the woman's clinical notes and, if one had not been completed, how had the prison doctors decided on her treatment?

13. The woman's family and solicitors have had an opportunity to consider this report. Some of their concerns have been amended within the report and

others have been responded to in separate correspondence. The woman's family remain highly concerned about the treatment of the woman, in particular in respect of the prescribing and nursing care at Bronzefield. They also commented on the availability of drugs in prisons.

HMP BRONZEFIELD

12. HMP Bronzefield is a modern, privately managed prison for women run by Sodexo Justice Services holding up to 527 women prisoners. It is 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. Primary healthcare is provided by Cimmaron UK with mental health care contracted to Alpha hospitals. The prison has a 24 hour inpatient healthcare unit which accommodates up to 18 women.

Previous deaths in Bronzefield

13. The woman's was the fourth death at Bronzefield. We have also conducted an investigation into the death of a woman who had been released from Bronzefield the day before she died.

14. Although the circumstances were different from those of the woman, in a previous report, we made a recommendation about the need for care in deciding dosage when prescribing without the supporting evidence of a community GP prescription. In another case there were some concerns about methadone prescribing practice.

Her Majesty's Inspectorate of Prisons

15. Her Majesty's Inspectorate of Prisons conducted an unannounced inspection of Bronzefield in October 2010. Inspectors had some concerns about the clinical management of substance users. This had improved but procedures were not yet operating effectively. At the time, the integrated drug system (IDTS, which aims to provide a community equivalent range of treatment and services for substance users) was not yet fully implemented or staffed. First night prescribing had been introduced but there was not always a doctor on duty in reception when required. Only one of the seven doctors had completed specialist training. Illegal drug use at the prison appeared relatively low.

Independent Monitoring Board

16. Each prison has an Independent Monitoring Board of unpaid volunteers from the local community who help to ensure that proper standards of care and decency are maintained. The most recent published IMB annual report is for 2010-11. The IMB reported that healthcare provision had notably improved since the HMIP report, with an action plan to address the issues raised by the IMB and HMIP, and changes to the management team. The IMB reported that IDTS had been fully implemented in April 2011, but the IMB was concerned about inadequate supervision of prisoners when methadone was being dispensed.

KEY EVENTS

17. On 14 January 2011, the woman was sentenced to three month and nine days imprisonment and went to HMP Bronzefield. She was a drug user. At her first health screen on the day she arrived, she said she had been smoking heroin, a habit which cost £40 a day, together with crack cocaine at £80 a day and took 50mg of diazepam. She said she was prescribed citalopram for depression and clonazepam for anxiety by her GP and methadone by the community drug team. The community drug team records were obtained on 22 January but there is no record that Bronzefield obtained her GP records. An entry in her clinical record on 14 January states "Had bzo [benzodiazepine test] in reception but test shows faint result."

18. The clinical reviewer notes that the woman did not receive any medication during her first night at Bronzefield on 14 January. However, this is incorrect and she was prescribed valium, buscopan, paracetamol and kalms, possible withdrawal symptoms. According to the clinical record, staff observed the woman hourly over the night of 14/15 January according to IDTS policy. It was noted that she slept well and did not show any signs of withdrawal.

19. On 15 January, Dr A, a GP at Bronzefield, examined the woman. The doctor noted that the woman said that she was taking 60mls methadone daily and had taken her last dose the day before. The doctor also noted that the woman was a heroin user, had good eye contact and was calm in her demeanour. The doctor prescribed a maintenance dose of methadone (10mls twice a day) and clonazepam (a benzodiazepine) (2mg) for anxiety and mirtazepine for depression.

20. The woman moved to a double cell on C wing on 15 January. She shared the cell with a cellmate, who told the investigator that they were related (second cousins). Both had drug misuse problems. The woman was observed throughout the night until 20 January (hourly on 15 and 16 January, and twice-nightly thereafter). During this time the woman did not report any negative symptoms. She was subsequently referred to the Counselling Assessment Referral and Advice Team (CARAT). She continued to receive 20mls of methadone daily.

21. On 22 January, Dr B, the prison IDTS doctor, saw the woman. He noted that the community drug team which had previously treated the woman had informed the prison that she had been discharged from their care and was last prescribed methadone on 19 November 2010. This was two months before her imprisonment. The doctor changed her prescription of clonazepam to a diazepam detoxification, reducing over a period of time. The doctor told the investigator that if the urine test indicated benzodiazepines a reducing dosage should be prescribed according to IDTS policy. He increased her methadone to 35mls a day because she was "symptomatic" but it is not recorded what those symptoms were. Another note on the same day by Dr C states, "No full reception drug screen noted. MTD [methadone] has been increased to 35 mls from 22 January by IW [Dr B]."

22. Dr B explained to the investigator that when a woman who was dependent on drugs came into prison, a urine test should be carried out. This is then tested for opiates and benzodiazepines. (Heroin is an opiate based drug and Valium is a benzodiazepine.)

23. When the investigator asked Dr B about the two entries in the clinical record which said that a full drug screen had not taken place, he said that a full urine test must have taken place for Dr A to have prescribed clonazepam on 15 January. He added that it was most likely that the full test took place but the results had not been fully recorded. Dr A told the investigator that he was meticulous about urine testing but agreed that it was possible that the results had not been recorded. The clinical reviewer, notes in his review that although it appeared that the woman's urine was tested for benzodiazepines, he could find no evidence that it was screened for opiates or methadone at this time.

24. Dr B reviewed the woman on 27 January. The woman told him that she felt stable on 35mls methadone and that she wanted to start to detoxify from it, with a view to changing prescription to buprenorphine on her release in March. (Buprenorphine, also known as subutex, is a drug which helps to reduce withdrawal symptoms when a person is detoxifying from opiates. They agreed that she would reduce her methadone by 1ml a day for five days, then maintain for two days before starting the same reduction process again. The doctor wrote in the clinical record "no drug screen".

25. On 10 and 11 February, the woman told Dr B that she was finding the detoxification difficult and that she wanted to increase to 40mls methadone per day because she would be leaving prison in four weeks. Her prescription was subsequently increased to 40 mls daily. This is the last note in the medical records detailing any appointments the woman had about her maintenance/detoxification programme.

26. On 7 March, the woman's cellmate said that she had woken as normal around 7.30am. She said that the woman was normally up and dressed at that time for her job as a cleaner, but that morning the woman was still in bed. The woman told her she had a bad migraine headache. The woman's cellmate said that she was aware that the woman suffered from migraine and so she did not think this was unusual. The woman's clinical record makes a number of notes about her receiving paracetamol for headaches.

27. The woman's cellmate went to work at the wing servery and took some breakfast back to the cell for the woman at around 8.00am. The woman's cellmate said that the woman opened one eye and seemed to "look straight through me as if I wasn't there." She said that the woman was sweating heavily and her hair was wet with sweat.

28. The woman's cellmate subsequently spoke to Prison Custody Officer (PCO) A, who told the investigator that he went to see the woman in her cell. He said the woman told him that she had a bad migraine from which she suffered regularly. PCO A said he advised her to go for her medication (methadone)

and get advice from the nurse. He said he asked the woman's cellmate to keep an eye on her he was on his own on the spur that day and to let him know if there were any problems.

29. The woman did not eat her breakfast but went for her medication and was given 40mls of methadone. The woman's cellmate said that the woman looked very ill at this point. PCO A said that he saw the woman going for her medication and described her as looking "doddery". One of the other prisoners brought a chair for her to sit on while she waited in the medication queue.

30. PCO A said he asked the woman what the nurse had said and she said that she had been told to rest. Nurse A and Nurse B were the dispensing nurses that morning. They both said that the woman did not tell them that she had a migraine and they did not notice anything unusual about her. According to the woman's cellmate when the woman got back to the room, she went back to bed and turned her face to the wall. The woman's cellmate said that she then went to talk to other prisoners for a while.

31. The police investigation found that a number of prisoners checked on the woman throughout the morning. The woman's cellmate returned to the cell around 10.45am and noticed that the woman was making noises, which she described as grunting or snoring. However, she said that the woman snored heavily so she did not think this out of the ordinary. She went back to work in the servery and returned to the room around 12.00pm with some lunch for the woman.

32. The woman's cellmate said that she shook the woman to wake her but noticed that her stomach was not moving. She called another prisoner and they realised that the woman was not breathing. They then called for help from staff. Officers came and then asked them to leave the room.

33. PCO A said that at about 12.20pm some prisoners, including the woman's cellmate, called for them to help the woman. He ran to the cell with senior prison custody officer (SPCO) A and PCO B. PCO A said he went into the cell followed by SPCO A and PCO B. SPCO A immediately called a code blue emergency over the radio. (A code blue is an emergency call for anyone with any breathing problems which might be life threatening).

34. PCO A said that the woman was lying on the lower bunk of the bunk beds and was "unresponsive to verbal [commands] and touch". He shook her shoulder and still got no response. PCO A thought the woman had died but he started cardiopulmonary resuscitation (CPR). He tipped the woman's head back to start CPR but realised he had to get her onto a firm surface to carry this out effectively and that the bunk above would impede effective CPR.

35. The officers tried to move the woman onto the floor of the cell but found it difficult because of her weight. Nurse C then arrived at the cell. The nurse told the investigator that he had just come on duty and he had been in the pharmacy area of houseblock 1 when he heard the code blue call. He knew

his colleague, who was the first emergency response that day was ll issuing medication so he took the emergency bag and responded to the call.

36. Nurse C said that the emergency bag contained oxygen, a face mask a CPR rescue breather and sometimes a blood pressure machine. He said that it did not contain a defibrillator which would be in another bag.

37. Nurse C told the investigator that it took him about three minutes to get to the cell after he had heard the code blue. He said that when he got there he saw PCO A and SPCO A. The woman was still on the bottom bunk, and the nurse described her as "bluish, cyanotic [cyanosis is a bluish tinge to the skin, and is a sign of a lack of oxygen]". He then assessed the woman, and noticed she was not breathing. He straightened her head so that he could use the airway, inserted it and started heart compressions while she was still on the bed. (An airway is a plastic instrument used to open the back of a patient's throat so that air can be passed through.)

38. The investigator asked Nurse C why he started compressions on the bed, rather than the floor which would have provided a firmer surface. The nurse said he could not move the woman to the floor because of her weight. He said that he did not count how many chest compressions he gave while he was administering CPR. Nurses D and Nurse E arrived after about five minutes with a defibrillator. Nurse E asked for the doctor to be called and more staff came to assist. They then moved the woman from the bed to the floor while one of the nurses prepared the defibrillator and ambu bag, which is used to administer oxygen. Nurse C continued giving compressions.

39. Nurse D removed the woman's bra in order to use the defibrillator effectively and found some fragments of tablets. This led the nurses to consider that she might have taken an overdose. The defibrillator was prepared but indicated that there was no shockable rhythm and directed the nurses to continue CPR, which they did until paramedics arrived.

40. The first ambulance was called at 12.20pm. The first responder arrived at the prison at 12.27 pm and took control of the resuscitation. A second ambulance arrived at 12.41.pm. Paramedics treated the woman at the prison for a while. At 1.20pm, the woman was transferred to the ambulance and taken to hospital. CPR continued throughout the journey.

41. An emergency crew was waiting to receive the woman at the hospital, but was unable to revive her. A hospital doctor pronounced her dead at 1.45pm, when he examined her in the ambulance when it arrived.

42. The Director of Bronzefield, a prison family liaison officer and a member of the chaplaincy team went to the woman's parents' home to inform them of her death at 4.15pm. They continued to liaise with the family and contributed to the financial arrangements for her funeral.

43. After the woman's death, a hot debrief was held. (A hot debrief enables staff to come together to discuss what happened, the emergency response and

support each other.) The staff said that they found it helpful and that it was positive that the ambulance had arrived so quickly.

44. Prisoners on the woman's wing were informed of her death and those who were subject to suicide and self-harm monitoring were reviewed to check they had not been adversely affected. Prisoners were offered support from staff and Listeners, and were reminded they could use Samaritan telephones. (Listeners are prisoners who are trained by the Samaritans to help when another prisoner needs to talk about confidential issues.)

45. All deaths in custody are investigated by the police, as well as the PPO. The police took the tablets that were found in the woman's bra and searched her cell. The tablets were subsequently found to be clonazepam which the woman was no longer prescribed.

Post-mortem and toxicology reports

46. The original toxicology report of June 2011, which was received by the police was inconclusive. The pathologist subsequently ordered a specialist toxicology report, which was received in December 2011.

47. A consultant forensic toxicologist, stated in the specialist toxicology report, :

> "…the toxicological findings indicate the therapeutic ingestion of prescription drugs prior to death as per her therapy. Although it is often difficult to interpret specific methadone concentrations, her described dose regimen would have produced significant tolerance and therefore reduces the probability of methadone being involved as the cause of her death."

48. The post-mortem report of 19 December 2011, from a consultant at St Peter's Hospital, Chertsey, noted that "though the toxicological opinion is that the methadone levels measured were unlikely to be the sole cause of death, it could be contributory." The report concluded that the cause of the woman's death was cardiomegaly (enlargement of the heart) and fatty degeneration of the liver, due to or as a consequence of obesity, contributed to by methadone toxicity.

ISSUES

Clinical Care

Reception

49. When the woman arrived at Bronzefield on 14 January she had a routine reception health screen. A note in the clinical record indicates that testing showed a faint positive for benzodiazepines. There is no record of a full drug screen urine test for opiates or methadone. The lack of a record of a full screen was noted by Dr C on 22 January and by Dr B on 27 January. Dr B told the investigator that, in order for the woman to been prescribed clonazepam, a full test must have taken place. He concluded that the test result must not have been recorded properly. Dr A told the investigator that he would only prescribe methadone if a test had been done and that he was meticulous about urine testing. However, it was over 18 months later, after the receipt of the clinical review when the investigator spoke to him about this and he was unable to be sure that one had been done in this case.

50. Although the woman said that she had been taking 60mls of methadone a day until she came to Bronzefield, the drug and alcohol service which treated her in the community informed the prison that she had been prescribed her last dose of methadone on 19 November 2010. We cannot know whether she had an illicit source of methadone before she came into custody or whether she misrepresented the position in order to ensure she obtained methadone in prison to substitute for illicit opiate use. Dr A prescribed a maintenance dosage of methadone at the prison on 15 January. This started at 10mls, twice a day and increased to 35mls a day. Once again, the clinical reviewer, comments that he could find no evidence that her urine was screened for opiates or methadone.

51. The woman was known to Bronzefield staff and there were previous clinical notes and information about her drug dependency. However, there is no record of a full urine test or reference to the drug service that treated her in the community to support the original decision to start her on a methadone maintenance programme. (The drug service had not prescribed methadone for two months). Nor did the prison obtain the woman's GP records, which would have helped staff know what she had been prescribed in the intervening period. It is important that prisons obtain as full a picture as possible of a prisoner's previous medical history. We make the following recommendation:

    The Head of Healthcare should ensure that community GP records are routinely requested for all new prisoners.

52. Nevertheless, there is some evidence that the woman had been dependent on opiates before arriving at Bronzefield. Her cellmate, who knew her from the community, accepted that the woman was a drug user. The woman herself said she was a heroin and crack cocaine user and she exhibited symptoms of withdrawal which led Dr B to raise her dose of methadone on 22

January. It is not possible to know the extent to which methadone toxicity contributed to the woman's death and we note the comments of the expert toxicologist that her tolerance to methadone "reduces the probability of methadone being involved as a cause of her death." Nevertheless, it is a concern that there is no available documented evidence to support the decision to start the woman on a methadone maintenance programme on 15 January when she first arrived. Either no urine test for opiates was done or the results were not recorded. We make the following recommendation:

The Director and the Head of Healthcare should ensure that methadone is prescribed only when a full urine test has been carried out and according to IDTS policy. The results of the test should be clearly noted on the clinical record.

Response to the woman's headache on 7 March 2011

53. On 7 March, the woman told her cellmate and PCO A that she was suffering from a migraine headache. Her cellmate said that she looked poorly and PCO A also said that the woman looked unwell. He said he asked the woman to consult the nurses about this when she got her medication.

54. The two nurses who were dispensing medication on 7 March, Nurse B and Nurse A, responded to some written questions put to them by the investigator. They said that they did not notice anything unusual about the woman and she did not tell them that she was ill. There was therefore no further treatment or follow up. The woman told PCO A that the nurses had told her to rest.

55. If the woman had told the nurses that she was ill, we would have expected there to have been some follow up treatment or observation, or a note of the conversation in her medical record. However, the nurses said that the woman did not tell them about her migraine. As there are differing accounts, it is not possible for us to draw any conclusion about the treatment the woman was offered that morning.

56. The officer on duty, PCO A, asked the woman to seek advice from the nurses when she received her medication. He checked after she had seen them and the woman said that she had been told to rest. He asked her cellmate to keep an eye on her during the morning and let him know whether there were any problems. As the woman's cellmate worked on the wing she, and other prisoners, were able to look in on the woman. At 10.45 the woman appeared to be sleeping and her cellmate did not think the grunting and snoring noises she was making were out of the ordinary. We are satisfied that PCO A had no reason to believe that the woman was suffering from anything other than a migraine which she had told him was not unusual. He believed that the woman had sought advice from the nurses.

57. Nevertheless, the woman was on a methadone maintenance programme and we consider it is important that staff in prisons trained to be vigilant for signs of methadone toxicity and check regularly on prisoners known to be on such a prescription when they report being unwell. Had the woman been checked by

a member of staff her apparent deep sleep, grunting and snoring sounds could have been interpreted as signs of methadone intoxication and indicated a need for concern, which might have alerted them to seek medical help. We do not know the extent to which methadone toxicity contributed to the woman's death and it is possible that she was simply asleep as normal during the morning of 7 March. However, it is also possible that she was displaying symptoms similar to drug-induced unconsciousness which might have caused concern had she been checked by a member of staff familiar with the symptoms. We make the following recommendation:

The Director should ensure that women prisoners on methadone maintenance and detoxification regimes who report unwell are checked regularly and that staff are trained to recognise the common symptoms of drug-induced unconsciousness and methadone toxicity and know how to respond.

Emergency response

58. When the woman was found in an unresponsive state, staff responded quickly, called a code blue emergency and began CPR. There was some difficulty moving the woman from the bed to a hard surface to carry out CPR, but as soon as other staff arrived, they moved her to the floor of the cell and healthcare staff carried out observations and CPR. A defibrillator was used appropriately, but there were no signs of a shockable rhythm.

59. Nurse C told the investigator that he did not take a defibrillator with him when he responded to the emergency. He took an emergency bag from the houseblock he was on, and it took another five minutes before a defibrillator was brought. It is impossible to know whether this would have affected the outcome for the woman, but in other circumstances it might prove vital. We make the following recommendation:

The Director and Head of Healthcare should ensure that a defibrillator is taken quickly to all code blue emergencies.

Drugs found on the woman

60. Fragments of a controlled drug (clonazepam) were found in the woman's bra, while staff were attempting CPR. The police and the investigator have been unable to establish where the clonazepam came from. The woman was prescribed clonazepam when she first arrived at Bronzefield but this was later changed to a diazepam detoxification and both medications were given under supervision and not in possession.

CONCLUSION

61. The woman had a long standing substance misuse problem and had been in Bronzefield previously. On arrival at Bronzefield, a health screen was completed but there is no record that a full urine test for drugs took place. The next day, she was placed on a methadone maintenance programme but there was still no record of a positive urine test for opiates. The clinical reviewer concludes that the woman was given appropriate and professional care at Bronzefield, but we are concerned about the lack of a recorded urine test for opiates before methadone was prescribed.

62. On the day of her death, the woman told an officer and other women prisoners she was suffering from a migraine. Nurses said she did not tell them she was feeling unwell when she went to get her medication that morning so there was no follow up treatment or observation. We consider there is a need for all staff to be vigilant when women prisoners on methadone maintenance or detoxification programmes report being unwell.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that community GP records are routinely requested for all new prisoners.

   This recommendation has not been accepted by the prison. They said, " We do seek clarification/confirmation from GP's in relation to prescription medication. Extensive medical records are requested on an individual basis for specific clinical decision making, but not for all patients, this would be operationally unviable."

2. The Director and the Head of Healthcare should ensure that methadone is prescribed only when a full urine test has been carried out and according to IDTS policy. The results of the test should be clearly noted on the clinical record.

   This recommendation has been accepted by the prison. They said, "IDTS provision within HMP Bronzefield commenced 1 April 2011 and is monitored by Surrey DAAT. NTA and PCT. Substance misuse policies in line with national guidelines are now in place. In line with IDTS policy all new receptions are urine tested on arrival to the establishment before seeing the GP and results recorded on the electronic clinical medical record. GP prescribing reflects urine testing results.

   Head of healthcare will ensure the director of Cimarron, GP providers, provides assurance and auditable evidence that GP's are adhering to policy and appropriate action is taken where it is not."

3. The Director should ensure that women prisoners on methadone maintenance and detoxification regimes who report unwell are checked regularly and that staff understand the common symptoms of drug-induced unconsciousness and drug intoxication and know how to respond.

   This recommendation has been accepted. The prison said, " …Local policies are in place in line with national and PSI 45/2010 guidelines. Twenty four hour nursing staff provision is now in place on the stabilisation unit and observations completed and recorded on electronic medical records for women undergoing detoxification as per policy guidelines."

4. The Director and Head of Healthcare should ensure that a defibrillator is taken quickly to all code blue emergencies.

   This recommendation has been accepted. The prison said, " Defibrillator machines are an addition to the emergency response bags, which are located on all houseblocks, in healthcare and in the reception area.

   Allocated House block nurses respond to Code blue emergencies on the respective houseblock and take the equipment to the patient. If the patient is in any other area of the prison eg workshop radio call sign for a nurse on Hotel 1 and Team leader Hotel 9 respond."