Investigation into the circumstances surrounding the death of a woman in July 2004 following her release from HMP Bronzefield earlier that day

Report by the Prisons and Probation Ombudsman for England and Wales

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CONTENTS

Introduction

This is the report of an investigation into the care a woman received whilst in prison custody before her death in July 2004 after release from HMP Bronzefield earlier that day.

Although the woman died after leaving prison, I decided to exercise the discretionary power included in my terms of reference to investigate her death. My reasons for doing so were first the public concern about the number of deaths of female prisoners. Second, the number of drug related deaths of prisoners shortly after their release from prison. Third, that she died so soon after her release from custody, and finally, that she had been a prisoner at Bronzefield, a prison that had only just opened.

This investigation was conducted by one of my Senior Investigators with whom I visited Bronzefield and met with both prisoners and staff.

The findings of this report will be considered by an advisory committee that I co-chair with the Head of the Women's Team in the Prison Service. Our aim is to identify any features that might be common to other deaths of women prisoners and to promote any good practice found.

I wish to extend my thanks to the Director of Bronzefield, and her staff, for their help and cooperation during the investigation.

Stephen Shaw CBE
Prisons and Probation Ombudsman

Summary

The woman was arrested in June 2004 for theft and a breach of a Community Rehabilitation Order. She was sent to HMP Holloway as a remanded prisoner and returned there a week later having been sentenced at Magistrates Court to a total of three months imprisonment. She had never previously been in prison custody. The woman had been a heroin user since 1990 and also used 'crack' and benzodiazepines. She underwent a drug detoxification regime at Holloway, which continued at Bronzefield.

In early July 2004, the woman was sentenced to a six months Community Rehabilitation Order at Magistrates Court for charges of theft, failing to provide a specimen and failing to appear. Instead of returning to Holloway, she was sent to HMP Bronzefield to complete her original three months sentence, in line with the current Prison Service protocol to allocate prisoners to the new facility.

The woman was released from Bronzefield two weeks later and went to stay with a friend. Later that evening she was found dead in the bath at that address.

The cause of her death was determined by a Coroner's inquest, but the Post Mortem examination carried out concluded that she drowned, with heroin poisoning as a secondary factor.

This investigation has revealed gaps in Bronzefield's processes as it operated in June and July.

Investigation methodology

1. My investigator and I opened the investigation at Bronzefield a few days after the woman's death. The Director and her staff produced her core file and a number of other documents for our examination. Subsequently, notices were issued to staff and prisoners informing them of my investigation. We toured the establishment and met informally with staff and prisoners. Several members of staff were also interviewed regarding the deceased woman in particular and Bronzefield in general. All interviews were informal.

2. Letters of condolence were sent to the woman's family. The letters also explained the purpose of the investigation and asked if there were any concerns or questions they would like explored and addressed.

3. My investigator contacted the Coroner's Officer, to brief him on the nature and scope of my investigation and request a copy of the Post Mortem report. Her Majesty's Coroner in this case expressed her desire to consider this report as part of her investigation process and my investigator subsequently attended and gave evidence at the inquest.

The deceased

4. The woman was 47 when she died. According to an interview with her Probation Officer, she had a troubled childhood, going into Local Authority care aged 14. Having left secondary education without qualifications, she worked in retail. During that time she married. She separated from her husband in the 1980's. Around that time, she was diagnosed as having cervical cancer and underwent radical surgery, which appeared to have fully cured the condition. She has three sons.

5. In 1990, she was allocated council accommodation and she allowed a drug using friend to stay in order to help him break his habit. Unfortunately, that situation resulted in her own addiction to heroin. For some years she was in an abusive relationship with a partner who was also heroin dependent. Their dependence was costing them £60 per day and their whole lives revolved around obtaining enough money for drugs

6. In 2003, in an effort to remove herself from the local ‘drug scene’, she moved in with friends in London. They were financially supportive of her and she was taking Subutex on a private prescription. This drug prevents withdrawal symptoms and nullifies the effects of any heroin taken. Unfortunately she had resumed taking heroin before her arrest in June 2004.

HMP Bronzefield

7. HMP Bronzefield opened on 17 June 2004. It is a purpose built women's prison operated by UKDS, a private company who also operate HMP Forest Bank in Greater Manchester. Whilst the deceased was at Bronzefield the prison held 148 prisoners. It will eventually accommodate 450 female prisoners. Accommodation is provided in three houseblocks with mostly single cells. There are inpatient facilities in the healthcare centre, a mother and baby unit and a special section for women with behavioural problems. Primary health care is provided by a local GP surgery, with a doctor attending each day on rota.

8. Bronzefield performs the role of a local prison, taking prisoners directly from the courts. Sentenced prisoners may serve some of their sentence there.

Events prior to the woman's death

9. The woman was arrested in June 2004 for theft and breach of a Community Rehabilitation Order. She was sent to Holloway as a remanded prisoner and returned there a week later having been sentenced at Magistrates Court to a total of three months in custody. This was her first period of imprisonment.

10. At her first reception health screen at Holloway, her medical history was taken. She told the nurse that she was not feeling suicidal at that time, although she claimed to have attempted to take her own life on two previous occasions (no dates given) by means of tablet overdose. She also told of her use of heroin, crack, cannabis and binge drinking of vodka. She was also using benzodiazepines. A diazepam and methadone detoxification programme began according to Holloway protocols. The methadone detox programme was completed in mid June 2004.

11. The woman was seen by healthcare at the end of June 2004 and a Self Harm at Risk Form (F2052SH) was opened at 15:00 hrs, as she was feeling depressed and tearful with some thoughts of self-harm. From the entries on the form, it would seem that her mood varied over the following two weeks. By mid July 2004, staff at Bronzefield assessed that she could be removed from the self-harm watch and the F2052SH form closed. There had been no incidents or attempts at self-harm.

12. On 5 July 2004 the woman attended Magistrates Court for charges of theft, failing to provide a specimen and failing to appear. She was sentenced to a six months Community Rehabilitation Order. Instead of returning to Holloway, she was sent to Bronzefield in line with the current protocol to allocate prisoners to the new facility.

13. A First Reception Health Screen form was completed again, with similar details to those on the Holloway document being provided. She was finding diazepam withdrawal difficult and was taking 12mg per day on arrival at Bronzefield. A doctor saw the woman the following day and decided to continue the ‘detox’ regime started at Holloway. She was seen again a couple of days later when she presented as agitated, tearful and weak. The doctor increased the dose of diazepam to 15mg twice daily for seven days.

14. A doctor saw the woman on the day before her release and recorded her as being much better. The doctor arranged for her to have one day’s medication to take home with her on her release. She was given a letter for her to take to any GP surgery to assist her to get an appointment. She did not collect the medication prior to leaving prison.

15. On release from Bronzefield, the woman went to stay with a friend, who arranged for her to see a local doctor at 15:30 hrs that day, as she had no medication. It is known that she also attended a pre-arranged appointment with a Probation Officer later that afternoon.

16. The woman returned to her friend's home in the early evening and decided to take a bath. She was found slumped in the bath sometime later and pronounced dead at the scene. The Post Mortem examination found that she drowned in the bath whilst suffering from heroin poisoning.

Emergent issues

17. The majority of the staff employed at Bronzefield are newly employed with no previous Prison Service experience. At the time of my visit, staff were still being recruited and trained as the prison population increased. Posters were on display to inform staff and prisoners of the local anti-bullying policy but no self-harm awareness posters were evident. The prisoners with whom we spoke expressed the view that the staff were friendly and helpful.

18. My investigator interviewed the Resettlement Advisor, who said that Bronzefield's targets of every prisoner being seen on the first night by a member of the resettlement team, and having a first morning interview on an Initial Resettlement Plan (IRP) lasting between 20 – 45 minutes, were both being met. The deceased woman had two IRP forms completed on the same day, by two different members of staff and containing some different responses from her. This remains unexplained. It may be that, as I was told, it resulted from a member of staff being "over zealous". Be that as it may, it is illustrative that in any new institution it takes a while for procedures to bed down. My investigator was informed that the form and the policy for its use were still evolving.

19. My investigator then spoke to a CARAT (Counselling, Assessment, Referral Advice and Throughcare) advisor who had spoken to the woman. She carried out the initial assessment on the houseblock. She found her very emotional, anxious but willing to talk openly. She told the advisor that she had been 'clean' of heroin for 10 months, had undergone detox in Holloway, was a heavy ‘crack’ smoker as well as a heavy benzodiazepine user. The woman was anxious regarding the level of medication she was receiving and had spoken to the doctor.

20. The CARAT advisor said that Bronzefield had insufficient ‘detox’ trained staff. In fact, there were no ‘detox’ nurses, only a visiting ‘detox’ doctor.

21. She saw the woman again about a week before her release. The woman was concerned that she had no doctor to go to, as she wanted subutex as well as her diazepam medication. She stated that she was not going to go back to using heroin but was looking forward to smoking ‘crack’.

22. The CARAT advisor told her that she had arranged various appointments for her post release with specialist drug advisors in the area she was intending to live. She also specifically told her about the dangers of drug usage after being in prison, although she was unable to give her any literature, as it had not arrived. I attach particular importance to warning prisoners of their reduced tolerance to drugs on release and commend the

CARAT advisor's involvement with the woman. It is regrettable that the relevant leaflets were not yet available.

23. The CARAT advisor was upset that a prisoner told her of the woman's death and that, when she spoke to the prison administration department, they had no details. She was de-briefed a few days later but felt that it could have been done sooner.

24. At the time of my initial visit, there were two CARAT advisors in place with another two due two weeks later. Literature and brochures regarding drug usage and self-harm were on order and Listeners were being trained that week.

25. My investigator spoke at length to another member of staff. She had spoken with the woman after finding her crying one day. She had a long conversation with her and after that spoke to her almost every day. She said that the woman took comfort from those meetings. Unfortunately, the member of staff had not been made aware of the requirements of the F2052SH forms, so none of the interaction with the woman was recorded.

26. The Deputy Director told me that the large catchment area of the prison posed difficulties with resettlement but that they were working to establish local contacts to assist. As a private company, UKDS runs the prison under a contract, which in this case was negotiated in March 2001. UKDS is currently in discussion to update the contract with particular reference to the provision of ‘detox’ services. I believe this should be given a high priority.

27. The friend with whom the woman went to stay after her release expressed anger to my investigator at not being told that her friend was potentially suicidal and that she had been released without any medication.

Findings and Conclusions

HMP Bronzefield

28. The staff at the prison are mostly newly trained, yet like the staff of other contracted prisons they appear friendly and helpful. The deceased woman was apparently happier at Bronzefield than at Holloway and even wrote a couple of letters of thanks when she left. However, it became obvious during this investigation that there were still some training issues - most notably, correct procedures for staff dealing with prisoners on an open F2052SH to be addressed as well as some administrative procedures that were not settled prior to the opening of the prison. The provision of detoxification services also needed to be reviewed.

29. **Conclusion** - *None of the training or administrative shortcomings contributed directly to the woman's death.*

Medication

30. The woman was concerned throughout her confinement within the prison system at the level of medication given to her. The doctor increased her dose of diazepam to 15mg twice a day when she saw her in early July, as she appeared agitated, tearful and weak. When she saw her a week later, she arranged for her to have three 10mg diazepam tablets (one days supply) when she was released the following day.

31. Although given her normal morning dose of diazepam on the day of her release, the woman left the prison without the tablets the doctor had arranged for her. My investigator spoke to the healthcare manager regarding this. He said that there had been staff training issues at that time and the reception staff sometimes released prisoners without informing healthcare. Procedures are now in place, including a member of the healthcare staff in the reception area from 7:00 hrs, to prevent this recurring.

32. We interviewed the three GPs from the local practice contracted by UKDS to provide primary care. They had very little experience dealing with drug addicted patients or their medical detoxification. They were anxious for some specialised training. A specialist ‘detox’ doctor attends four times a week and healthcare now have three ‘detox’ trained nurses.

33. **Conclusion** - *On and before 16 July 2004, proper procedures were not in place to prevent mistakes such as occurred on the woman's release or to ensure that prisoners received appropriate clinical care on release.*

Self-harm monitoring procedures (F2052SH)

34. A form F2052SH was opened for the woman whilst she was at Holloway and remained open during her transfer to court and then to Bronzefield where it was closed after a review three days before her release. She was not present at the closing review. This was not in line with best practice.

35. When she arrived at Bronzefield, a First Reception Health Screen was completed for her. There is no mention on the form that she was subject to an open F2052SH. A supplementary form entitled 'Further reception health checks' was also completed, stating 'received from HMP Holloway fit & well'. Again there was no mention of the open F2052SH. My investigator interviewed the nurse, who stated that she had not seen the F2052SH booklet when she conducted the first reception health screen with the woman. She is now aware of her responsibilities regarding the use of that document and would have noted her documentation if she had seen it.

36. The Inmate Medical Record for the woman did not contain any references to the F2052SH. On 22 September 2004, my investigator interviewed three doctors who were the GPs who had treated her at Bronzefield. They were not aware that she had been subject to an open F2052SH booklet and stated that when they see prisoners on self harm watch 'the booklets don't usually appear'.

37. During an interview with the Director of Bronzefield on 22 September 2004, my investigator was told that there has been specific F2052SH staff training since July and that will continue.

38. I acknowledge the woman's friend's concern about not knowing she had been potentially suicidal. There are confidentiality issues that would prevent that information being divulged to other persons without the express permission of the prisoner.

39. **Conclusion** - *On and before 16 July 2004, some Bronzefield staff who came into contact with prisoners were not aware of their responsibilities to those prisoners on F2052SH booklets nor the correct procedures for their use.*

Notification of deaths

40. Both the CARAT advisor and the other member of staff interviewed who spent time with the woman were upset that they heard of her death from prisoners.

41. **Conclusion** – *On or before 16 July 2004, staff became aware of a significant incident from prisoners rather than official sources.*

Recommendations

42. Whilst I believe that the procedural, training and administrative shortcomings detailed above did not directly contribute to the unfortunate death of the woman, the investigation has raised some concerns about Bronzefield's readiness to receive prisoners in June and July 2004. I list them below along with the response of the Director

43. Prior to a new facility being opened, especially one that will receive many drug-using prisoners, there must be sufficient appropriately trained staff in place. Any equipment and documentation those staff might need should also be available to them. Service Level Agreements should be reviewed prior to opening to ensure the establishment can meet the standards laid down ensuring the safe effective care and resettlement of prisoners.

44. **Director's response –** *The staffing levels and training programme were fully approved by the Home Office prior to the prison opening. All operational policies were submitted by the Contractor to the Home Office to schedule and were approved prior to cell certification being issued.*

45. A multi-agency policy should be developed and implemented to ensure that appropriate and effective throughcare is available to all prisoners on release into the community.

46. **Director's response** – *Bronzefield is a pilot site for the Drugs Intervention Programme (DIP). The prison is currently putting in place arrangements to accommodate this.*

47. A policy should be developed to ensure that prisoners are given appropriate referrals to clinical care services in the community to provide a seamless service.

48. **Director's response** – *The DIP arrangements referred to above are designed to assist in bringing together a range of agencies around those with drugs problems who are known to services. Bronzefield's Healthcare Centre and CARAT's teams will work in partnership with the community under DIP arrangements.*

49. The Director of Bronzefield should ensure as a matter of urgency that all her staff are properly trained in the use of the F2052SH booklet.

50. **Director's response** – *Training on the F2052SH system was focused on those staff who would come into contact with prisoners. All Prisoner Custody Officers were fully trained prior to opening the prison. The member of staff referred to in paragraph 27 had been recruited as an Administrator and as such had not been trained. This has since been rectified.*

51. The Director of Bronzefield should ensure that staff are made aware of significant incidents and that details of such incidents are communicated to staff and to prisoners through official channels in a sensitive and timely manner.

52. **Director's response** – *The staff briefing system is now much more robust than it was at the time of this incident.*

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