PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

Investigation into the circumstances surrounding the death of a woman at HMP & YOI Holloway in January 2012

Report by the Prisons and Probation Ombudsman for England and Wales

January 2013

This is the report of an investigation into the circumstances surrounding the death of a woman. She was found at the beginning of January 2012 in her dormitory at HMP Holloway suffering from severe blood loss. She was taken to outside hospital where she died the following day. She was 52 years old. A preliminary post mortem report indicated that her death was due to an intracranial bleed[1]. I offer my condolences to her family and friends.

The woman arrived at Holloway on 14 December 2011, having been repatriated from Vietnam, where she had been imprisoned for drug related offences. She had a serious heart condition and, while in custody in Vietnam, had spent a considerable amount of time in hospital receiving treatment.

The investigation was undertaken by an investigator. A review into the woman's medical care was undertaken by a clinical reviewer, who was commissioned by the local PCT. HMP Holloway cooperated fully with the investigation. I apologise that the report has been delayed.

The investigation found a number of serious omissions in the care the woman received. These included inadequate handover of a prisoner being repatriated under medical escort, a failure to ensure appropriate medical records were received by relevant clinicians, a range of failures to meet medicine management standards, not following up referrals for external medical appointments and poor recording practice. Of particular concern, was there inadequate nursing attention received in the hours before her death. While we cannot say with certainty that her life could have been saved with better care, it is clear there were a number of missed opportunities to afford her appropriate treatment.

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 **January 2013**

[1] An intracranial haemorrhage is a haemorrhage, or bleeding, within the skull

CONTENTS

SUMMARY

1. The woman received a life prison sentence in Vietnam in 2007. While in Vietnam, her medical records highlighted that she had been diagnosed with mitral stenosis and second degree heart function deficiency[2]. She had been treated by the National Institute of Cardiology and a General Hospital in Hanoi. In September 2010 and September 2011, she was admitted to hospital in Hanoi with chest pain. As a result of her illness, she was prescribed a number of medications

2. She was repatriated back to the UK to serve her sentence and arrived at HMP Holloway early on 14 December 2011. The escorting nurse was unable to provide a verbal handover or physically pass her medical notes to healthcare staff as none were available. The notes were later faxed by the escorting nurse but they did not find their way on to her clinical record, nor did records that had been sent in advance of her arrival.

3. That morning she was seen by a prison doctor, who used an interpretation service to assess her and confirmed she had a serious heart condition. The medication with which she arrived with was checked and re-prescribed.

4. During her stay at Holloway she complained of experiencing stomach and back pains, nausea and headaches. She was seen by healthcare staff on a number of occasions and her care reviewed. Tests were also undertaken which later involved the cessation of some of her medication. One of the medications prescribed to her in Vietnam was unknown to healthcare staff at Holloway. Subsequently, fewer checks and tests were undertaken than would have been expected for someone with her serious heart complaint.

5. At the beginning of January 2012, she complained to other prisoners in her dormitory of having pains in her side and head. The nurse on duty attended her dormitory. Despite being asked to attend the dormitory door hatch so the nurse could speak to her and carry out an assessment, she failed to respond. She was seen to be breathing and to be moving one of her legs from side to side but could not communicate. Despite several attempts by other prisoners to get her to speak to the nurse at the hatch, she did not respond. The nurse did not consider that she needed any further assessment or treatment. She did not enter the dormitory and left after five to ten minutes.

6. When staff unlocked the dormitory at about 7.47am, she was found by officers. She was breathing but unconscious, and was losing a lot of blood from her mouth and nose. Staff attended to her and called an ambulance. She was transferred to hospital. The next day, her life support machine was turned off and she was pronounced dead. The provisional cause of her death was identified by the interim post mortem as an intracranial bleed.

[2] Heart disease involving the narrowing of valves in the heart.

7. We make nine recommendations as a result of this investigation, which identified a range of weaknesses in her healthcare and treatment. These included inadequate handover of a prisoner being repatriated under medical escort, a failure to ensure appropriate medical records were received by relevant clinicians, a range of failures to meet medicine management standards, not following up referrals for external medical appointments and poor recording practice. There was also a serious lack of care exercised by the nurse who attended the dormitory when her health deteriorated.

THE INVESTIGATION PROCESS

8. One of the Ombudsman's investigators visited Holloway on 11 January to open the investigation. He met with the Governor, a member of the Prison Officer's Association (POA) and Independent Monitoring Board (IMB). The prison appointed a DPSM as their liaison officer for the investigator.

9. The investigator issued notices inviting staff and prisoners to contact him with any information they thought might be relevant to the investigation. He subsequently interviewed three prisoners. He was provided with copies of the woman's prison and medical records covering her brief time at Holloway.

10. The local PCT commissioned a clinical reviewer to review the clinical care the woman received at Holloway. She and the investigator carried out joint interviews with staff in February, March and May 2012. The Governor of Holloway was given written feedback on the progress of the investigation in March 2012.

11. According to the terms of reference of this office, when an investigation report criticises an identified member of staff, we will advance disclose a draft of the report. In this case, the report was shared with the prison, the PCT and the private healthcare provider, because it was an agency nurse who was criticised. No comments were received following the advance disclosure of the report from any of these parties.

12. Her Majesty's Coroner for the City of London was notified of the investigation. The Coroner will receive a copy of this report to assist with his enquiries.

13. We apologise for the slight delay in issuing this report. This was due to the complex issues that arose during the investigation along with the unavailability of crucial witnesses which also affected the completion of the clinical review.

14. Three repatriation escorting officers, one of whom was the deputy Head of Healthcare at HMP Wandsworth, travelled with the woman from Vietnam to the UK. The investigator spoke with her over the phone and she provided a statement to be used as part of the investigation.

15. One of the Ombudsman's family liaison officers contacted the woman's daughter to explain the purpose of the investigation and invite her to raise any questions or concerns. Her daughter raised the following concerns:

    - Her mother had complained about being ill and was having difficulty breathing, and the family would like to know what was done about this.

    - The family were told by the prison that her mother saw a doctor (GP) and that a translator was present. However during a telephone call that she made to her daughter, she said she did not have a translator during the GP appointment.

16. Her daughter also received a copy of the draft report as part of the consultation period. She had no further comments to make about the investigation.

HMP HOLLOWAY

17. Holloway is one of 13 female prisons in England and Wales. It can hold up to 501 women, in single or dormitory rooms.

Her Majesty's Chief Inspector of Prisons (HMIP)

18. The most recent inspection by HMIP was in April 2010. It said;

> "Health services were provided by a range of different agencies and were due to be re-commissioned. Women in our survey were not positive about the overall quality of health services, but some work was under way to deal with identified concerns, including complaints about nurse attitudes and delays with appointments. Staff shortages had put pressure on services and had affected the regular delivery of the full range of nurse-led clinics."
>
> "Primary care staffing levels appeared adequate and included a small administrative team. However, there were four vacancies out of 15 whole time equivalent (WTE) registered nurses and only one permanent GP. We were told that security clearance for newly appointed members of staff was taking up to six months and that some staff who had been appointed had been lost to other employers because of the delay. Health care vacancies were covered by agency staff, but the number of vacancies was affecting the routine delivery of some clinics, which had become ad hoc leading to inequalities in accessing services."

Reception

19. When a prisoner arrives at a prison, their records are handed over by the escorting contractor. The prisoner is booked in by staff at the front desk, their details are checked against the documentation and the relevant files are opened. Prisoners wait in a waiting room and see staff individually. They are searched, their property is checked and they are given clothes and information about prison. Prisoners are then escorted to the First Night Centre where they will receive a health screen.

Emergency response

20. Emergency codes are used to summon staff to deal with a particular situation. Holloway uses two medical emergency codes which are called over the radio: Code Blue for life threatening emergencies and Code Black when there are no signs of life. During night state, wing staff carry a cell key in a sealed pouch but, except in a medical emergency, only the orderly officer can open a cell door at night. The night orderly officer is in charge of the prison at night supported by assistant response officers.

21. A member of healthcare staff is assigned to attend emergency situations and carries the radio call sign Hotel 1. He or she has a red emergency bag with them which includes basic medical equipment for initial treatment for emergencies such as anaphylaxis, fitting and suspected opiate overdose.

Roll check

22. The roll check is the physical count of the number of prisoners on each wing within a prison. Roll checks occur on a number of specified occasions during the day and night, and staff sign that the roll is correct.

Previous deaths at Holloway

23. This is the fifth death from apparent natural causes at Holloway since 2004 when the Ombudsman became responsible for investigating all deaths in prison custody. None of these had similar circumstances to that of the woman.

KEY EVENTS

Events before the woman's arrival at HMP Holloway

24. The woman was born on in 1959 in Hanoi City, Vietnam. She married in 1977 and in 1980 went to live and work in Hong Kong with her family. In 1982, they moved to the United Kingdom and were granted asylum.

25. On 26 June 2004, she returned to Vietnam for a visit. While there, she was arrested and charged for drug related offences. She was later sentenced to life imprisonment in Vietnam.

26. In 2010, the woman applied through the Vietnamese Government and the UK embassy to transfer to the UK to continue her prison sentence. This was granted and arrangements were made for her to be repatriated[3] to the UK.

27. While in the Vietnamese prison, her medical record showed that she had been admitted to a General Hospital on 13 September 2011. She had complained of chest pain and shortness of breath. A number of medical investigations were carried out, including blood tests, ECG (electrocardiogram, a test that measures the electrical activity of the heart), x-ray, ultra sound and urine tests. A report was completed by the hospital doctor on 5 October 2011 and she was diagnosed with atrial fibrillation[4], mitral valve disease/ heart failure. As result of her poor health, she was prescribed a number of different medications.

Escort arrangements and responsibilities for the woman's repatriation from Vietnam to the UK

28. The Prison Service repatriation team initially had some difficulties in finding an appropriate nurse to accompany the repatriation team of one male and one female prison officer. The Deputy Head of Healthcare at HMP Wandsworth volunteered.

29. It appears that medical information was sent to Holloway in advance of the woman's transfer and filed in the custody office. It was not shared with healthcare staff.

30. Before travelling to Vietnam on 9 December 2011, the nurse was provided with a translated medical report for the woman, which described her heart condition. On 13 December, she was collected by the nurse and two UK prison officers. A Vietnamese doctor was present (with an interpreter) and together with the woman and the nurse, they went through the medication she had in her possession. Although the nurse did not recognise the medication names, as they were Vietnamese, she said she was confident that they were prescribed to manage her heart condition. The woman appeared fully aware of when she had to take each of her medications.

[3] Repatriation is the process of returning a person back to one's place of origin or citizenship.
[4] Atrial fibrillation is the most common cardiac arrhythmia (abnormal or irregular heart beat).

31. The doctor confirmed that the woman was fit to travel to the UK. The nurse described the woman's command of English language as "fairly poor" but she was able to communicate a little. She talked during the journey and said she was looking forward to seeing her family. She slept during the long flight and took medication as prescribed. At the time of leaving Vietnam, she had served nearly seven and a half years in prison.

The woman's arrival handover to HMP Holloway

32. The repatriation team arrived in the UK on Wednesday 14 December 2011 and arrived at Holloway around 6.40am. This was slightly earlier than the nurse had anticipated. The prison barrier was still shut and they were requested by prison staff to wait until 7.00am before bringing the woman into the reception area.

33. At 7.10am, along with one of the escorting officers, the nurse spoke with the reception senior officer (SO). The woman stayed in the prison van outside with the female escorting officer.

34. The nurse said the SO was not expecting the woman. The escorting prison officer explained that the necessary information regarding her was passed to Holloway the previous week and should also be in their reception diary. According to the nurse, the SO did not check the diary. The nurse told the investigator that she wanted to handover the woman to healthcare staff to explain her health condition. This request was apparently twice declined by the SO, who said it was too early and no one was available. She was told to fax the paperwork to the healthcare department or speak to someone there later.

35. In contrast, the SO told the investigator that the nurse had requested to see a doctor to carry out the healthcare handover. She made no mention of a diary in reception. She said that no doctor was in the prison at that time of the morning. However, she would call a nurse. The SO said that despite two attempts to contact a nurse via the Communications Room, no nurse responded. The investigator found no record of a nurse being requested. A Developing Prison Service Manager (DPSM), responsible for healthcare told the investigator that his was not unusual because it was not an emergency, it was a request. It would have been around the handover period between the night duty nurse shift coming to an end and the day nurse shift beginning, and staff are normally busy at this time.

36. As a healthcare handover was not possible, the nurse returned to the escorting vehicle to collect the woman. Aware of how the reception process worked, she ensured she self-administered her prescribed morning medications. The nurse said she faxed the medical information to Holloway's healthcare centre. The fax front cover sheet for this was provided to the investigator by the DPSM. It confirmed it was sent on Wednesday 14 December 2011 at 12.02pm (although the name of the patient and prison number on it was incorrect and related to a male prisoner). It is not known with any certainty what happened to this paperwork. Healthcare staff told the investigator it was not attached to the woman's medical file during her stay.

The woman's reception screening at Holloway

37. From 7.30am onwards, the woman was seen by a number of staff to take her through the reception process. The SO and an officer recorded basic details about her, including that she spoke little English and had four children. The officer told the investigator that had she had concerns about the woman's ability to communicate, she would have used the Language Line interpretation service.

38. The woman was allowed to use the telephone and spoke with her daughter. She was provided with an information pack about the prison, which staff said they explained to her to ensure she understood. A cell sharing risk assessment (CSRA) was completed by the officer and recorded the woman as a "Standard Risk", which indicated that she was no immediate risk in respect of sharing a cell with others.

39. After this, she was taken to the First Night Centre, D2 wing where her induction to the prison continued. An officer completed the booklet entitled "Holloway Passport" which recorded further details about her including health issues. The passport booklet requested a "yes/no" answer to the question, "Do you require an interpreter". Neither yes or no were indicated, instead the words "speaks little English" were entered in the adjacent box. It is also recorded that her first language was Vietnamese. In relation to her health, the officer recorded that she had no alcohol, drug or mental health issues and was currently taking "heart medication".

40. At around 11.10am, the woman received a basic reception health screening from a Healthcare Assistant (HCA). She carried out a urine test for drugs and recorded no issues of concern relating to the woman's CSRA. As Holloway normally receives prisoners in the evening, qualified nurses were not available to carry out a health screen. At this time of morning, nurses are normally issuing medication to prisoners and conducting clinics. She was therefore referred to see the prison doctor first, and would see a nurse later in the day.

41. A doctor examined the woman at 12.43pm. He enlisted the support of the prison's telephone interpretation service, Language Line, to conduct his medical screening with her. He recorded that she had a history of coronary heart disease[5] and hypertension[6]. She was currently taking anticoagulants[7] for hypertension and this medication should continue. It was recorded that she should be referred for a cardiology assessment. The doctor described her as "middle aged woman appears tired. Physical exercise restricted".

42. The following table identifies the medication the woman was taking and which arrived with from Vietnam:

[5] Coronary heart disease is a narrowing of the blood vessels (coronary arteries) that supply oxygen and blood to the heart.
[6] Hypertension or high blood pressure means that your blood pressure is constantly higher than the recommended level.
[7] An anticoagulant is a substance that prevents coagulation (clotting) of blood.

Generic Name	Strength	Purpose
Valsartan tablets 80mg	80mg	Valsartan is used to treat high blood pressure
Metoprolol tablets 25mg	25mg	Metoprolol is used to treat several different problems. It works on the heart and blood vessels and can reduce hugh blood pressure.
Acenocoumarol tablets	4mg	An anticoagulant. Anticoagulant medicines reduce the ability of the blood to clot. If the blood clots too much, blood clots can form which can lead to conditions such as a stroke.
Digoxin tablets	250mcg	Digoxin increases the strength and vigour of heart contractions, and is useful in the treatment of heart failure
Lisinopril tablets	5mg	Used to treat high blood pressure or heart failure.
Spironolactone /Furosemide tablets	50mg/20mg	Known as diuretics are often referred to as water tablets. Spironolactone is known as a potassium-sparing diuretic because it does not cause your body to lose potassium. Spironolactone is used to treat oedema (too much fluid causing swelling). It prevents the build-up of fluid by increasing the amount of urine produced by the kidneys. Spironolactone with furosemide is used to treat oedema (water retention) which is often caused by liver disease, kidney problems or heart failure.
Nitroglycerin tablets	2.6mg	Nitromin contains the active ingredient glyceryl trinitrate, which is a type of medicine called a nitrate. It is used to help the heart work more easily.

43. As shown in the table above, the medication acemocoumanol is an anticoagulant. The investigator was told by the Head of Pharmacy that this medication was not very well known in the UK. The closest equivalent to this medication in the UK is warfarin[8]. Nonetheless, the woman was to continue to take acemocoumanol at this stage.

44. The doctor re-prescribed the woman's medication based on the medication she arrived with (listed above) at Holloway. He replaced the nitroglycerin tablets with a nitromin spray. All the medication, except the nitromin spray, was prescribed as Not-In-Possession medication, meaning she would not be

[8] Warfarin is the main anticoagulant used in the UK. An anticoagulant is a medicine that stops blood from clotting.

permitted to retain the medication within her cell. Her medication was now detailed as follows:

Generic Name	Strength	Dosage
Lisinopril	5mg	28 tablets (one daily)
Acenocoumarol	1mg	112 tablets (four daily)
Metoprolol	50 mg	28 tablets (1/2 tablet daily am)
Valsartan	40mg	28 tablets (1 capsule daily am)
Spironlactone/ Furosemide	50mg/ 20mg	28 tablets (1 capsule daily am)
Nitromin	400 micrograms/dose pump spray	(1 puff as needed)
Digoxin	250 microgram	28 tablets (1 tablet daily am)

45. The woman's prescription chart and her own medication were taken to the pharmacy department for checking and labelling. Pharmacy staff did not receive an In-Possession (IP) paper prescription for nitromin 400mcg spray, which the doctor had prescribed. The medication and prescription chart were later returned to healthcare, where they were held ready to be dispensed to her at appropriate times.

46. When he examined the woman, the doctor noted that she was taking anticoagulant medication for atrial fibrillation. However this was not recorded on her medication chart, which is the physical document nurses would first refer to. As she had been diagnosed with atrial fibrillation, normal medical standards dictate that the examining doctor should record the patient's recommended International Normalised Ratio[9] (INR) range, which is 2.0 – 3.0. Nurses need to be aware of this for monitoring purposes.

47. The Deputy Head of Healthcare told the investigator that procedurally when a prisoner arrives and is on anticoagulants, the pharmacy team should ensure that they have a recent INR level recorded. This information should have been instigated by the doctor on reception who should record the expected INR range. Nurses, if they are administering an anticoagulant, should also be familiar with the patients INR range in order that any abnormalities can be reported to the doctor. The investigation found that the doctor had not requested an INR test when the woman arrived. He was also not able to confirm her medical history as she arrived with no medical information.

48. A nurse conducted a secondary health screening around 4.26pm. He told the investigator that there were no medical records for the woman and all he had to refer to were the doctor's entries on SystmOne (the computerised medical record) as well as her bag of medication which had been brought to the healthcare office.

[9] An INR blood test gives an indication of how quickly blood clots.

49. The woman was said to have spoken sufficient English for her to answer questions put to her by the nurse. She talked about her medication and said she was due to take a dose of furosemide. As he had reviewed the doctor's entry about her history, the nurse allowed her the medication. He recorded her basic vital observations[10] including weight (47kg, 7st 6lb), height (1.57m, 5ft 2ins), blood pressure[11] 94/64mmHg (which is lower than the normal) and pulse, 70bpm (which is average).

50. The nurse said that he was not familiar with her medications, and in particular the anticoagulant she was taking. The name of this was written in Vietnamese on the medication label. He was aware that if a patient was taking anticoagulants, their INR levels should be monitored regularly.

51. The woman was subsequently allocated to dormitory (17) on D2, the first night and induction unit. Over the next two days, she completed her prison induction. An officer conducted an induction interview and issued her with a quick guide support document. She also signed the relevant prison compact agreements stating that she understood and would abide by the prison's rules.

52. Over the weekend (16-18 December), her blood pressure was taken by a nurse and recorded as 124/79mmHg. At some point that day, she received paracetamol, although the reason given which was written on her prescription chart is illegible. She also received a visit from her daughter.

Monday 19 December

53. The woman missed a routine appointment with the prison doctor in the Wellbeing Centre on the morning of Monday 19 December. No reason was given. However, D wing staff contacted healthcare around lunchtime because she had complained of feeling unwell. A nurse went to the wing to see her and found her lying on her bed with her eyes closed. She complained of stomach and back pains, nausea and dizziness. He took her observations and recorded her blood pressure (109/68mmhg), pulse[12] (56bpm) and temperature[13] (37.0C). Following his examination, his main concern was that her temperature was slightly high and in light of her medical history, referred her to see the doctor that afternoon.

54. A doctor saw her at 2.17pm. She said she suffered from angina pain[14], atrial fibrillation and hypertension and was on medication. She complained of having chest pain every now and again and felt faint. She also explained that she experienced "shakes in hands" and was tired all the time. He noted her medical history on SystmOne as "cardiac disease monitoring". He referred her for an ECG (electrocardiogram, a test that measures the electrical activity of the

[10] Vital signs are measurements of the body's most basic functions. Main vital signs routinely monitored by medical professionals include body temperature, pulse rate, and blood pressure.
[11] Normal blood pressure is when your blood pressure is 120/80 mmHg or lower most of the time. High blood pressure (hypertension) is when your blood pressure is 140/90 mmHg most of the time. If your blood pressure numbers fall between 120/80 and 140/90, it is called pre-hypertension.
[12] The average resting heart rate for an adult is between 60 and 100 beats per minute
[13] Normal body temperature can range from 36.5 degrees Celsius to 37.2 degrees Celsius.
[14] Angina is a pain or discomfort felt in the chest.

heart), FBC (full blood count test), U&E (Urea and Electrolytes, blood test for functioning of kidneys and levels of various salts in the blood), LFT (liver function test) and TFT (thyroid function test). He also noted that she should be referred to a cardiologist. There is no entry in the clinical record to show whether the ECG took place, or, if it did, the result.

Tuesday 20 December

55. The following morning (20 December), a nurse took blood samples from the woman and sent them to a hospital laboratory for examination. These were for FBC, renal, liver and thyroid functions. After having her blood taken, she said she felt faint. Her blood pressure (108/70mmHg) and pulse (68bpm) were taken and recorded.

Wednesday 21 December

56. At about 11.10am, the hospital telephoned prison healthcare and confirmed that one of the woman's blood test results had indicated that she had a high level of potassium[15], measured at 6.2. (High potassium level indicates a risk of heart attack and acceptable range is considered to be 3.5 to 5.0). A doctor discussed her condition and the blood test results with the Lead GP at Holloway.

57. The doctors agreed to stop her diuretic medication (Spironolactone / Furosemide) until further notice. Blood tests were also be repeated (for FBC, digoxin levels, INR, liver, renal, bone, and glucose) and an ECG carried out. The Lead GP told investigators she felt it necessary to check the woman's digoxin and INR levels (via blood test) because she was taking an anticoagulant. The blood samples were taken and couriered to the hospital that afternoon. Again there is no reference to the ECG or any results in the clinical record.

58. Around 8.50pm that evening, aware that the woman's test result had still not been returned by the hospital, the doctor contacted them. He was told the test results were not ready and would be telephoned through to Holloway later that night. He would review her in the morning. No call was received from the hospital.

59. The next day Thursday 22 December (3.17pm), the hospital telephoned and confirmed that the woman's potassium level was within an acceptable range (potassium result of 4.9 recorded), however her digoxin level was high, 2.1 (accepted range is 0.8 – 2.0). The doctor who reviewed the results contacted the hospital and requested fax copies of both of her recent blood test results. No INR result was provided by the hospital. The Lead GP told the investigator she contacted the hospital to ask why an INR test result was not returned although requested. The hospital said they had no record that a blood sample for this was received.

60. A doctor noted that the woman's digoxin medication should be stopped for two days. This decision was documented on SystmOne. However, it was not made

[15] Potassium is a mineral that the body needs to work normally. It helps nerves and muscles communicate.

clear on the medication prescription chart that digoxin should not be administered on 23 and 24 December. It is recorded on the prescription chart that she was given digoxin from 23 - 28 December 2011 with no omissions. Two digoxin doses were omitted on Thursday 29 and Friday 30 December 2011. There is no endorsement (signed or dated) on the medication administration chart by the doctor stating when the decision was made or when the digoxin should have stopped.

61. In addition, as her potassium level was now within an acceptable range, the investigator found no record that the medication that was stopped (spironolactone/furosemide) was reviewed or restarted by the doctor when the blood results were received.

62. Between 22 December and 1 January 2012, it appears that she did not have contact with anyone from healthcare as there were no entries made in her clinical record. She moved to a normal residential wing, unit C4 room 11 on 23 December. This was a five bed dormitory and occupied by four other women.

63. A Wing Officer told the investigator that he worked regularly on C4 and D4 wings. He was familiar with the woman, who he described as a "quiet lady, polite, didn't speak much English". Although staff were reluctant to use prisoners as interpreters for other prisoners, she would use one the women she shared a dormitory with, to help her communicate with staff, when necessary. The officer described her as being comfortable with this method of communicating. Her cell mates were considered to be well behaved, trustworthy and caused staff no disciplinary problems. She had told the officer that she had a heart problem and was taking medication for this.

Events from 1 January 2012

64. It was noted on the woman's prescription chart that she was given paracetamol on for a headache. The following morning she was seen in the nursing clinic by a nurse. The nurse noted that she had experienced headaches for a long time (years) and "would like to be investigated for her heart". She was given paracetamol again for her headache and advised to submit an application to see the doctor. Her pulse (60bpm) and blood pressure 120/70mmHg) were also recorded.

65. The next morning at 10.46am, while collecting her daily medication, she complained of chest pains. She was taken to the healthcare centre for an ECG to be carried out. She was seen by a prison doctor in the afternoon. One of her cell mates told the investigator that before going to healthcare the woman had been banging her head on the wall because of her bad headache.

66. The doctor told the investigator that she did not feel that the woman's command of the English language was sufficient for her to carry out a medical consultation. She therefore used the Language Line interpretation service during their consultation. The woman said she had been in hospital in Vietnam and had a long standing heart condition. She found it hard to breathe and was experiencing chest pain everyday, sometimes for a few hours and sometimes

for an hour. The pain at night was worse when lying on her side. She said her chest pain spread to her ear and then her head. Her headaches, which she had experienced for over a year, made her want to bang her head. She was also having problems with her eyes and complained of visual problems.

67. The doctor examined her. She listened to her heartbeat and chest and they appeared normal. She was concerned about her chest pains, especially given her medical history and planned to refer her for a cardiology assessment. (The doctor told the investigator that it was the doctor's responsibility to make the referral and it was her intention to complete a letter template on SystmOne to make the referral to the hospital the next day). The doctor noted on SystmOne that the woman had atrial fibrillation and hypertension (blood pressure recorded as 138/77mmHg). An ECG should be carried out that day and olive ear drops were prescribed because of wax found in her ears. Glyceryl trinitrate 400mg/dose spray was also prescribed to alleviate her chest pains. There is no record of the ECG taking place or any results.

68. The woman was again given paracetamol at around 5.50pm that evening by the nurse on duty, having complained of a headache.

69. During the day wing staff and the woman's cellmates said there were no concerns raised about her. Her cell mates had said she was in a good mood having recently received flowers from her children. They ate their dinner and she took her medication as normal before they all settled down for the evening and watched television.

70. Holloway accommodates approximately 500 prisoners. During the night state, one nurse is responsible for all the wings except for H1 (substance misuse unit) and C1 (in-patient /mental health assessment unit). These two units have their own dedicated nurses. The nurse responsible for the rest of the prison therefore can be very busy, as her role includes responding to healthcare requests to see prisoners, administering medication, preparing the next day's medical records as well as being the first healthcare responder in emergencies.

71. Officer A arrived for his night duty shift at 7.45pm. He collected his sealed key pouch and radio. He was based on C4 and B4 that night. His first task was to conduct the evening roll check and to ensure all prisoners were present and responded when checked. He also received a handover from the staff finishing their duty. No issues were raised.

72. When he checked the woman's dormitory (cell number C4 - 11) he recalled that all seemed normal. The women were all sitting up watching the television.

73. Later that night, he responded to the cell bell for dormitory 11 (11.58pm as recorded on the cell bell printout sheet). When he arrived, a prisoner (located in first bed on the right hand side of cell) had a toothache and wanted painkillers. He contacted the nurse on duty[16] (radio call sign Hotel 6) via the

[16] Nurse on duty who is responsible for all wings except for H1 and C1

Communications Room. Nurse A subsequently telephoned the wing and said she would attend as soon as possible as she was very busy. She arrived about 1.55am. She stopped at the cell and gave the prisoner paracetamol before telling the officer what she had done.

74. Prisoner A (in the first bed on the left hand side) told the investigator that, when the nurse had attended their dormitory to see the other prisoner, the woman (located in the bed next to her on the left hand side) tapped her and asked if it was the nurse that was at their cell door. She said yes, however she appeared to go back to sleep. Prisoner B (whose bed was on the opposite side of the room to the woman) said that soon after the nurse had left, she saw her trying to get up from her bed but struggled and laid back down. She alerted Prisoner A to this.

75. At his point, (about 10 minutes after the nurse had left), Prisoner A said the woman tapped her again requesting that a nurse be called. She complained of having a headache and took hold of the prisoner's hand, placing it on the side of her head where the pain was. She also gestured with her hands that she was experiencing pains in her side and while she remained lying down, kept repeating the words "pain, pain". The prisoner got out of bed and turned on the cell side light and pressed the cell bell for assistance. All four prisoners in the dormitory were now awake and sat up in their beds.

76. Around 2.09am (as recorded on the cell bell printout sheet), the officer confirmed that he again responded to the cell bell for dormitory C4 – 11. Prisoner B said the woman was unwell. He asked what was wrong with her because he was aware of her limited English. He was told that she had complained of having a headache and could not move. From the observation panel, the officer could see her lying on her bed on her back. Her left leg was outstretched, her right leg bent up in air, her right hand was on her stomach and her left hand was outstretched sticking out of the bed. Her knee was moving from left to right. He left the cell to call the nurse immediately as he remembered she also had a heart problem.

77. He again contacted the Communications Room and requested Hotel 6. He said Nurse A telephoned the wing and was not happy that she had been requested to return to the wing so soon after leaving. He explained that the call on this occasion was for a different prisoner, the woman, who was not well. Her response to this was that she would attend the wing when she could as she was busy.

78. The nurse arrived at 2.30am and, together with the officer, attended dormitory 11. In the short time it took to get to the dormitory from the wing office, the officer said he told the nurse that the woman had a heart problem. The cell light was turned on and the nurse opened the cell hatch. He stood next to her and looked through the observation panel on the dormitory door. He could see the woman's face although this was obscured at times because of the other prisoners standing in front of the panel. His impression however was that the other prisoners in the dormitory were not happy about what was going on.

79. The nurse tried to speak to her to find out what was wrong. She did not respond. The other prisoners in the cell were speaking on her behalf alerting her to the nurse's presence. The nurse asked her to come to the hatch so she could be treated. There was no verbal response from her.

80. Prisoner A told the nurse that the woman had a headache, was tired, felt dizzy and needed painkillers. She took her identification card to the hatch to show the nurse in order to get medication for her as she felt she was unable to walk unaided. The nurse said that she would have to get up and present herself at the hatch. The prisoner offered to assist her to walk to the hatch but was told by the nurse not to in case she hurt herself.

81. Along with the other three prisoners in the dormitory, Prisoner A said they all continually "pleaded" and called the woman's name, asking her to "get up" and attend the hatch to speak to the nurse and collect medication. She, however, did not respond. Her eyes were closed now although her leg was still up and moving. The prisoner said that the nurse's response was that she could not give her any medication if she did not come to the hatch as she did not know what was wrong with her. Prisoner B said the other prisoners continued to call her, telling her the nurse was there. The prisoner also told the nurse that the woman had a "heart problem". This was said to have been acknowledged by the nurse, who responded that this would not stop her from sitting up and talking.

82. Prisoner A recalled that the nurse said she could assess the woman from the hatch and that, as she had not got up, she could not treat her and intended to leave. On hearing this, all the prisoners asked the nurse to give them one more chance to get her to respond. All four prisoners again called out to her but she did not respond. The prisoner said her lack of response left all her cell mates surprised as she had always responded to them in conversation. Shortly after, the nurse and the officer walked away from the outside of the dormitory. She said that the woman had begun to snore quietly and, thinking she was tired, they all left her to sleep.

83. The officer confirmed that the women told the nurse that the woman was not well enough to get out of bed. He said that the nurse repeated that she had to come to the hatch herself to be treated. The officer said it was at this point he asked the nurse what she wanted him to do. By this he meant (and told the investigator) that he was happy to obtain permission from the Night Orderly Officer (NOO, officer in charge of the prison) to unlock and enter the dormitory. He thought she would want to do this to assess her. The nurse said no and again repeated that she would have to come to the hatch to be treated.

84. Under normal circumstances, authority to unlock a cell at night must be given by the Night Orderly Officer (NOO) and no cell will be opened unless a minimum of two/three (subject to local risk assessment procedures) members of staff are present one of whom should be the NOO. During night state, prison and healthcare staff, such as the officer, carry a sealed key pouch. The pouch can be broken in an emergency situation in order to enter a cell. Healthcare

staff have the authority to request a cell be opened for medical assessment under Prison Service Instructions.

85. The nurse told the investigator she had no previous contact or knowledge of the woman. When she was called to the wing and escorted to the dormitory by the officer, he had only told her she was not feeling well. She found the woman was lying on her side. She called her name but she failed to respond and the other prisoners said she did not speak English. The nurse described having to "calm the girls in the dorm down" as they were concerned about her, although she was unclear about what they actually were saying. She also said that she was not told why she had asked to see a nurse.

86. The nurse said her clinical assessment of the woman was that she was not distressed and her appearance was "fine". Her leg was moving and her hand was "waving me away". She interpreted her movements as a signal for her to go away as she was not needed. The nurse said no one had told her that she had a heart problem, had a headache or pains in her chest in the five or so minutes that she spent at the cell hatch.

87. Referring back to events as recalled by the officer, he said that along with the nurse, they spent about ten minutes at the cell door before the cell light was turned off and they left. He returned to the wing office and the nurse accompanied him. She said she intended to wait in the wing office for about ten minutes to see whether the cell bell for the dormitory was pressed again. This would, she said, save her time from having to come back to the wing.

88. After approximately ten minutes, the officer said the nurse left the wing. He returned to the dormitory where the occupants said that the woman was sleeping. He told them to keep an eye on her and to alert him if they had any concerns. Prisoner A said they all turned off their side lights shortly after 4.00am. During this time she appeared to be asleep. Her leg had now lowered and she continued to snore. During the officer's normal pegging[17] duty throughout the night, he looked into dormitory 11. It was quiet and dark as the lights were off. He believed the occupants had settled and were all now asleep.

Roll check the next morning

89. Officer B began his day shift on the wing around 6.50am. Along with Officer A they conducted the morning roll check. Officer B said that, when he arrived at dormitory 11 on C4 wing, he turned the light on. He could not see the woman's face as she was facing away from the dormitory door, but could see she was breathing and her leg moved. He was content that all the correct prisoners were present and alive. Officer A recalled that the position she was lying in had changed from when he had last seen her during the night.

90. Officer B worked on C4 wing and he knew the woman. He said she spoke broken English but staff were able to communicate with her. She mainly socialised with the other prisoners whom she shared a dormitory with and who

[17] Pegging duty consists of the officer patrolling the wing landings at various times.

supported and assisted her. On the occasions that she felt unwell, (complaining of head and stomach pains and feeling weak), he recalled it was the women who she shared the dormitory with who had helped her.

91. Officer C arrived on the wing about 7.20am and, along with Officer B, attended the wing morning meeting. After this, the two officers began to unlock the cells on the wing, around 7.45am, for the women to attend their various day time activities.

92. On arriving at dormitory 11, it was still dark inside. The officers unlocked the door and switched on the light. Two of the women were already up and dressed. The officers went in the cell. Officer C told the investigator that she initially spoke to the prisoner in the first bed on the left. She was standing up and so obscured her view of the woman's bed, which was next to it in the middle. When their short conversation ended, she stepped further into the cell and closer to the bottom of her bed.

93. As she looked over, she saw the woman lying flat on her back. She saw blood coming from her mouth and nose, running down her body. She immediately alerted Officer B. Officer B radioed a Code Blue emergency (recorded on the communication log as occurring at 7.56am) through to the Communications Room. He then ushered the other prisoners out of the dormitory and returned to assist Officer C. Officer B also saw blood gushing from the woman's mouth. Her face also appeared disfigured. Although previously first aid trained, the officers had not received any recent refresher training.

94. The woman was still breathing and so the two officers placed her in the recovery position. Officer C supported her back, Officer B supported her front and legs. As they had turned her onto her side, blood came from her mouth and nose onto the bed sheets. Her back was also wet, possibly from blood and other body fluids. Officer C described her breathing as "very laboured". A SO then entered the cell. She immediately told Officer B to call a further medical emergency. The SO replaced Officer B supporting her, who locked the women on the wing back into their cells.

95. An officer and a SO were in the C4 landing office when they heard the Code Blue emergency call. They responded and arrived at the cell within seconds. Both were shocked at the woman's appearance. She was still unresponsive. The officer began taking a log of those entering and leaving the cell.

96. It took second officer in charge of prison, known as Oscar 2 about 45 seconds to arrive at the cell having heard the Code Blue emergency call. She was aware that nurses were in the process of administering medications on the wings, and wanting to reiterate the seriousness of the emergency, again called over her radio that medical assistance was required immediately. Another SO also arrived at the cell.

97. Nurse B begun his duty at 7.15am and was allocated as the Hotel 1 radio carrier. This meant he was assigned as the first response nurse in any emergency. He had received a morning handover from Nurse A. She raised

no concern about the woman and nothing had been documented about her attendance at the dormitory during the night. One of Nurse B's first tasks was to carry out the medication round, which he started on C3 landing at about 7.40am. This meant he was in the medical room, at the hatch, dispending medication to prisoners who waited in a queue. Very soon after beginning this task, he received the radio call request for Hotel 1 to respond to C4 landing for an emergency response, Code Blue.

98. Nurse B was delayed as he first had to secure the medicine trolley and lock all the doors. He explained to the prisoners who were waiting for medication that he had to attend to an emergency which was greeted with hostility. He then went to C4 landing and arrived at the dormitory at approximately 8.00am.

99. He confirmed that the woman was lying in the recovery position, on her left side facing the window (her back facing the door) with Officer C supporting her back. He saw her bed sheets were heavily blood stained and blood was coming from her nose and mouth. She was unconscious, her face was discoloured, her cheeks swollen and, although she was still breathing, was making a high pitched noise and her pulse was weak. From his initial assessment, he thought that she had had a stroke or experienced a cerebral bleed. This was because of the discharge of blood stained fluid from her mouth and the fact that she had facial palsy and looked disfigured. He immediately requested an ambulance to be called said he needed further medical assistance from healthcare staff.

100. As Hotel 1, Nurse B carried the red emergency medical bag. This is normally used for emergencies such as cuts, self harm and fitting. On seeing the woman's condition, he required the blue emergency bag which contained equipment such as a defibrillator, suction machine and an oxygen cylinder. As he left the cell to collect this (located on the same landing), Nurse C arrived. She collected the bag while he returned to the woman.

101. Another nurse arrived at the cell and assisted Nurse B. By now, it was approximately 8.03am. The Deputy Head of Healthcare arrived and remained outside the dormitory to offer assistance should it be required.

102. While keeping the woman in the recovery position, the three nurses used emergency equipment to try and maintain her airways. Her pulse was still faint and oxygen was administered to assist with her breathing, which was very shallow. There was a lot of thick blood and mucus in her mouth and when the nurses tried to insert an airway support, they found her jaw was rigid. They had difficulty using the suction machine when trying to remove the thick blood and secretions from her mouth. They replaced the suction machine with a manual back up machine when this was not successful. Given her frail condition, Nurse B instructed staff to lift her mattress, with her on in, onto the floor. This was so they had more space to work, especially if her condition was to deteriorate.

103. The Lead GP arrived at the dormitory around 8.08am to assist. She told the investigators that the nurses were doing all they could possibly do to help the woman and were just awaiting the arrival of the ambulance.

104. The paramedics arrived at 8.10am and were given a verbal handover from Nurse B. This included the difficulties staff had experienced inserting an airway into the woman's mouth and using the suction machine. They were provided with a printout of her medical record by nursing staff.

105. The woman was assessed using the paramedic's equipment. Her pupils were fixed and dilated and they used their suction pump to try and remove some of the fluids from her mouth before preparing her to be taken to outside hospital. A SO had arranged for two escorting prison staff to accompany her to hospital. Given her condition a risk assessment deemed that restraints would not be applied. The SO also arranged for her relevant prison records to be collated and given to the paramedics to assist the hospital with background information. The ambulance left the prison at 8.37am and took her to hospital.

106. Given the seriousness of the woman's condition, a prison family liaison officer (FLO) was appointed. There was some initial difficulty determining the correct contact details for the woman's daughter as a telephone number was not recorded. However, a number was traced and passed to the Governing Governor, who telephoned her around 10.00am and her family attended the hospital very soon after this. The Head of Security and Operations visited the hospital that afternoon and spoke with the family.

107. The Governor ensured that all other relevant staff and agencies were aware that a serious incident had taken place. This included the chaplaincy department, the police liaison officer and the staff Care and Support team.

108. A hot debrief was carried out by the Governor around 10.45am for staff that had attended the woman's dormitory. Staff were visibly upset at the condition they had found her and talked about the events of the morning. One of the issues raised was that the suction machine had not worked properly. The prison Care and Support team attended to offer support to staff who were reminded to complete statements detailing their involvement in the incident. The woman's cell mates were individually spoken to, interviewed and offered support from the Samaritans and Listeners. It was also decided to review all prisoners on open ACCT[18] documents. (A critical debrief took place around three weeks later which was well attended by staff.)

109. The Lead GP was the medical liaison officer between the prison and the hospital and was kept updated on the woman's condition. She was undergoing tests and being monitored. One of the test results showed that her INR level was greater than 10 (which means the risk of suffering a haemorrhage was increased). This was extremely high with her level expected to be three. Later that morning, the hospital confirmed that her condition was critical and it was unlikely she would recover. Further tests were undertaken.

110. During the Lead GP's conversation with the hospital, it was discovered that that they had some background medical history about the woman's heart condition.

[18] The Assessment, Care in Custody and Teamwork (ACCT) system is a Prison Service-wide process for supporting and monitoring prisoners thought to be at risk of harming themselves

This had been given to them by the paramedics who in turn received it from Holloway. Amongst this was a Vietnamese hospital discharge summary report and an undated report from a Medical Centre in the UK. The latter identified that the woman had been registered with the medical centre since 1993 and had been diagnosed with mitral stenosis and aortic regurgitation[19] in 1988. She had been on warfarin[20] since 1994 and had been reviewed by the cardiology department in the UK in 2003. The report documented that "I understand this lady is in prison. She must be monitored for her INR by her prison doctor and should continue her warfarin tablets". The Lead GP confirmed that the prison healthcare centre had not had sight of this information. The Deputy Head of Healthcare and the Governor later confirmed that this medical information had been found attached to her core prison and warrant record file which was located in the prison custody office and not, as would have been expected, in her medical record.

111. The next day, a governor, accompanied by the FLO attended the hospital and met with the woman's family. Updates received from the Lead GP indicated little chance of her recovering and hospital tests confirmed she was deemed clinically dead at 11.00am. Her life support machine however was not to be turned off as the family were waiting for one more family member to arrive. The governor who was at the hospital later telephone the prison to confirm that the life support machine was turned of around 3.40pm.

112. The FLO remained in daily contact with the family and discussed the process of what would happen next. This included funeral arrangements, and the family were offered financial assistance as per prison national guidelines. The family visited the prison on 10 January and met with the Governing Governor, staff and other prisoners from her dormitory. Her property was returned to her family on this day.

Other relevant issues raised during the course of the investigation

113. After the woman's death the Head of Pharmacy conducted an investigation into her medicine management. This was submitted to the Interim Head of Healthcare. A number of issues were highlighted, including the lack of access to her full medical history and need for better monitoring of patients on anticoagulants. Recommendations were made.

114. The Head of Healthcare also confirmed to the investigator that, following staff concerns about the suction pump not working properly, it was checked. The suction pump was found to be in full working order but had been used incorrectly by staff when attending to the woman.

[19] Aortic regurgitation is where blood leaks back through the aortic valve as the valve does not close properly.
[20] Warfarin is the main anticoagulant used in the UK. An anticoagulant is a medicine that stops blood from clotting.

ISSUES

115. The woman had serious medical conditions that required treatment and monitoring. The clinical review makes a number of recommendations to improve policies and practice. While we cannot be certain that her life could have been saved, there were a number of missed opportunities and serious omissions in her care.

116. For ease of reference these issues have been divided into those before 3 January, and then those that occurred after.

Clinical care prior to 3 January 2012

Communication

117. It is apparent from the investigation that Holloway had been notified in advance of the woman's arrival and received medical information from Vietnam about her medical history. This information was not passed onto the healthcare department. Reception staff were also unaware of her arrival. The fact that her arrived with a medical escort was an unusual occurrence which in itself should have alerted reception staff to the seriousness of her medical condition. She had a long standing heart condition, possessed a large quantity of medication, had just completed an extremely long journey and was tired. We find it difficult to understand why these factors taken together did not cause staff greater concern.

118. Holloway has healthcare staff on duty 24 hours a day. Despite this, the unavailability of a member of the healthcare team also prevented a full medical handover between healthcare and the escorting nurse on the woman's arrival. This was an ideal opportunity for the escorting nurse to provide useful medical history, face to face, and physically pass documentation on, thus reducing the risk of misunderstanding about her illness or medication.

119. In the absence of a verbal handover, the written clinical notes were even more important. It is difficult to say with certainty why the woman's medical information was not shared with healthcare staff, other than through human error. The first copy of this information was inadvertently attached to her core prison file with other non-medical prison documentation. The second piece of information was later faxed through by the escorting nurse. The front sheet of the fax referred to a male prisoner but the attached paperwork related to her. It is unknown what happened to this paperwork. Although it could be that having read the front cover of the fax and believing it referred to a male prisoner, it was shredded on the presumption it had been sent in error to a female establishment.

120. This highlights a clear break down in communication which resulted in important information not being available to be used to complete a more comprehensive medical assessment of the woman in a timely manner. We therefore make the following recommendation:

The Governor and Head of Healthcare should ensure there is an effective handover of verbal and written information between healthcare and prison staff when a prisoner is being transferred or repatriated with a nursing or medical escort. This process should be reflected from the planning stage, arrival in reception and admission into the prison.

Prescribing and medication issues

121. A number of prescribing and administration practices were highlighted by the clinical reviewer. These, she said needed to be addressed to ensure safer medicines management at Holloway. The Head of Pharmacy also raised these in her report. Overall, some practices did not conform with the standards of professional service expected for medicine management. In particular, the investigation highlighted the following issues:

- No INR level or range was recorded for the woman on her arrival at Holloway. Any prisoner who is on anticoagulant medication must have their dose, target INR and latest INR test results confirmed in writing and recorded in a (anticoagulant) booklet, the medicine chart and in SystmOne.

- The woman's medication spironolactone /Furosemide were stopped on 21 December following a high potassium blood level test result. There was no record that this medicine had been reviewed or restarted when the blood results returned on 22 December 2011 stating that her potassium level was now within an acceptable range.

- It took seven days from an amendment of the prescription to omit two days of digoxin. This request was documented in SystmOne on 22 December 2011. However there was no date or signature on the medicine chart, nor was the chart amended to identify on which days to stop the digoxin.

- An in-possession glycerin trinitrate GTN spray (a spray to reduce chest pain) had been prescribed on 14 December 2011. This was not dispensed or administered to her.

- Nursing staff were administering an anti-coagulant (Acenocumarol) with which they were unfamiliar. This was not in line with professional standards for medicines management.

122. Staff were unfamiliar with the woman's medication and the recognition that she was on anticoagulant was not fully understood by all.

123. Medical professional guidelines include doctors' duty in regards to monitoring patients who are being treated with anticoagulants. In the UK the principal anticoagulant is warfarin. (Patients require anticoagulant therapy to slow down

the clotting process of blood either because they are at increased risk of clot formation or they already have a clot. The International Normalisation Ratio (INR) is the measure which is used in order to ensure that patients are maintained within a narrow therapeutic range (the therapeutic range being the safe boundaries for their condition).

124. Appropriate monitoring and adjustment of anticoagulant dosage is critical in maintaining the safety of patients. If the dosage is too low, there is significant risk of clotting with associated consequences which may include strokes. If it is too high, there is significant risk of uncontrolled bleeding or haemorrhage. The potential consequences, therefore, both of the dosage being too high and too low can be life threatening.

125. In view of the above, we make the following recommendations:

The Head of Healthcare should ensure that all patients on anticoagulants are monitored in line with professional standards of medicine management. This should include having their INR and medication reviewed using regular and documented timeframes.

The Head of Healthcare should ensure that medical, pharmacy and nursing staff prescribe, dispense and administer medication in line with professional standards of medicine management.

126. The record keeping aspect the woman's medical care fell short of the professional medical guidelines. Omissions included: lack of dates, signatures and diagnoses to identify the purpose of medication and a lack of recording of whether ECG's had taken place and their results. A further example was her referral for a cardiology assessment. Despite three separate referral entries on SystmOne on 14, 19 December 2011 and 3 January 2012, no referral was made. The Lead GP at Holloway confirmed that this responsibility lay with the examining doctor. He or she would be expected to immediately or at least within the next day or two, write a referral letter to the hospital to start the process. A doctor did say that she followed this procedure and it was her intention to write a referral letter on 4 January.

127. The woman had a long term serious illness and, while Holloway had a range of appropriate clinicians and access to secondary health care, at that time it had no clinics for the management of people with chronic diseases. Consequently there was limited consistency in the staff who had contact with her and the overall co-ordination of care (e.g. chasing up blood results and INR results, arranging cardiology appointments) was limited. .

128. Since her death, Holloway has developed clinics to manage prisoners with long term illnesses. We do however make the following recommendations:

The Head of Healthcare should put in place a robust process to ensure timely referrals are made for external hospital appointments.

The Head of Healthcare should ensure that, if prisoners are received who have long term chronic illnesses, they can be managed appropriately with consistency of care and prompt investigations.

The Head of Healthcare should ensure medical records are maintained in accordance with medical professional guidelines. All investigations and their test results, including commentary from ECG monitoring, should be entered into SystmOne within an identified timeframe of less than one week. Clinical action as a result of these tests should be documented.

Events after 3 January 2012

129. If the doctors who came into contact with the woman before 3 January had had all the relevant information and test results, it may have altered their view and course of treatment of her. However, in the individual consultations with doctors and nurses, although she had a serious heart disease, she did not present with an immediate life threatening condition. Her deterioration in health appeared to significantly and dramatically occur during the late part of the evening before her death.

130. When Nurse A was asked to see her that evening, the evidence suggests that concerns about her health were made clear. Prisoners with whom she shared a dormitory and the landing officer told her that the woman had heart problems and was not well. Prisoner concerns were heightened by the fact that she did not respond to them or the nurse. There is no question that she was breathing, but she was not verbally responsive. The nurse chose not to seek permission to enter the dormitory and instead attempted to assess her through the hatch.

131. At interview, the nurse was unable to give a clear clinical impression of the woman when she attended the cell. She also said she was not told she had a heart condition. This contradicts the prisoner and staff witnesses. Furthermore, the nurse chose not to check, or make an entry on her clinical records on SystmOne before or after her contact with her, something that may have assisted her decision making when making her assessment.

132. Following the woman's death some remedial action was taken by Holloway. They undertook an investigation into the nurse's actions. As she was an agency nurse, this also included liaison with the recruitment agency that employs her and her employment at Holloway was ceased immediately.

133. In addition, the Director of Offender Health Care for Holloway circulated a memorandum on 19 January 2012 entitled "access to unwell prisoners in periods of lock-up" to all prison health nursing staff. This memorandum outlined a nurse's responsibility when conducting clinical assessments, which included using all the available information, how to seek authorisation to enter a cell and the importance of documenting care.

134. We cannot see how a nurse can make a reasonable, informed clinical assessment without examining a patient and at the very minimum, obtaining basic vital observations (eg pulse, blood pressure). The woman's health

deteriorated to such an extent that around four and a half hours after the nurse attended the cell, her life could not be saved.

135. We cannot know if earlier intervention or examination would have prompted calling an ambulance and saved her. However, we do consider the lack of assessment a very serious matter.

136. The following recommendations are therefore made:

The Primary Care Trust should refer the nurse to the Nursing Midwifery Council for failure to clinically assess the woman in January 2012

The Head of Healthcare should remind clinical staff that, when asked to review a prisoner, they should consult SystmOne to ascertain relevant medical history.

Response to the emergency

137. A swift response was made by officers, nursing and medical staff to ensure that emergency action was taken and an ambulance called. Following the woman's death, it was decided that the holder of the Hotel 1 radio (the first nurse responder to an emergency) would no longer undertake roles that could delay their response (e.g. administering medication in the mornings). This action is fully supported by this investigation as it further contributes to the prevention of any delay in responding to emergencies. As a result of this action being taken, we do not make a recommendation in this regard.

138. In addition, during the incident it was noted that the electronic suction pump was not working adequately. It was subsequently established that it had not been connected correctly. The investigator was told that since the woman's death, staff had received training to use suction machine correctly. Suction pump checks are now part of the overall checks of emergency equipment. Although, the investigator and the clinical reviewer found out during the course of the investigation that checks are not always carried out weekly. The following recommendation is made in relation to the issues above:

The Head of Healthcare should ensure that all emergency equipment, including suction equipment, is checked at least weekly. This should be documented.

139. The investigators were struck by the level of trauma experienced by many staff as a result of witnessing the emergency. There has been on-going support from the prison.

140. Previous investigations into deaths in custody by this office have shown it is essential that an adequate number of discipline staff, who are usually the first responders to medical emergencies, have up to date first aid training which enables them to start CPR. Although this was not key to this particular case, establishments need to review their first aid arrangements for prisoner-related incidents and, where inadequacies are identified, put in place remedial action.

The Chief Executive of the National Offender Management Service has written to prisons in his letter dated 29 October 2010 to remind them of this, and so no recommendation is made on this matter.

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CONCLUSION

141. The woman had a serious and chronic illness when she arrived at Holloway and disclosed this to healthcare staff. She was taking medication to treat her illness and her health required rigorous monitoring.

142. However, the investigation has identified a range of weaknesses in her healthcare and treatment. These included inadequate handover of a prisoner being repatriated under medical escort, a failure to ensure appropriate medical records were received by relevant clinicians, a range of failures to meet medicine management standards, not following up referrals for external medical appointments and poor recording practice. There was also a serious lack of care exercised by the nurse who attended her dormitory when her health deteriorated.

143. That said, the woman was thoroughly assessed by the prison doctor the day before she was discovered unconscious in her cell. She was coherent and engaged well with the doctor. Her condition appeared to have drastically deteriorated over the next 36 hours. This was unexpected and it cannot be known whether, had she received better care on the night she died, the outcome been different.

144. When staff discovered her unconscious and bleeding, they acted promptly and professionally in their attempts to save her life.

RECOMMENDATIONS

1. The Governor and Head of Healthcare should ensure there is an effective handover of verbal and written information between healthcare and prison staff when a prisoner is being transferred or repatriated with a nursing or medical escort. This process should be reflected from the planning stage, arrival in reception and admission into the prison.

   The National Offender Management Service accepted this recommendation, writing:

   "The Governor will issue a notice to all staff emphasising the importance of ensuring that any medical information arriving into the establishment is routinely passed to a member of the Healthcare team as a mandatory action.

   Reception, OCA and Custody staff and managers will be briefed so as to ensure that relevant information pertaining to such women is communicated to the appointed points of contact within the Healthcare team.

   Reception managers and staff and all Healthcare staff, in particular, will be briefed so that a direct handover from the escort nurse to a member of the Healthcare team is ensured in all such cases."

2. The Head of Healthcare should ensure that all patients on anticoagulants are monitored in line with professional standards of medicine management. This should include having their INR and medication reviewed using regular and documented timeframes.

   The National Offender Management Service accepted this recommendation, writing:

   "Processes with accurate and required record keeping practices and appropriate management checks will be put in place.

   A local anticoagulants policy will also be drafted and implemented.

   An E learning course has been sourced on anticoagulants and will be completed by all GPs and the Pharmacy team."

3. The Head of Healthcare should ensure that medical, pharmacy and nursing staff prescribe, dispense and administer medication in line with professional standards of medicine management.

   The National Offender Management Service accepted this recommendation, writing:

   "An annual Medicines Management Audit Plan has been put in place.

A Medicine Administration Competency Assessment framework will also be put in place for all nurses to complete every 3 years. Any skills deficits will be met with training and development plans, and proportionate performance management."

4. The Head of Healthcare should put in place a robust process to ensure timely referrals are made for external hospital appointments.

   The National Offender Management Service accepted this recommendation, writing:

   "SystmOne has now been set up so that alerts automatically come through if a referral has not been actioned within the required timeframe (2 weeks). The Externals Appointment Clerk now routinely monitors these alerts and rectifies any issues as they arise."

5. The Head of Healthcare should ensure that, if prisoners are received who have long term chronic illnesses they can be managed appropriately with consistency of care and prompt investigations.

   The National Offender Management Service accepted this recommendation, writing:

   "The management of such individuals will be reviewed by the Primary Care team and care plans will be established with improved monitoring systems. The identification of such patients will be improved by an update to the reception template and the cleaning up of read codes to improve the accuracy of LTC registers. Regular LTC clinics will also be established, and an audit plan put in place. GPs will commence use of QoF templates to ensure the management of care is appropriate, with the use of the templates alerts system to assist."

6. The Head of Healthcare should ensure medical records are maintained in accordance with medical professional guidelines. All investigations and their test results, including commentary from ECG monitoring, should be entered into SystmOne within an identified timeframe of less than one week. Clinical action as a result of these tests should be documented.

   The National Offender Management Service accepted this recommendation, writing:

   "The Head of Healthcare will ensure that the GP team is briefed to ensure that ECG results are routinely entered onto SystmOne.

   Results come through automatically from our Pathology Services, and we are in the process of reviewing our Pathology provision and ascertaining whether it is possible to automate pathology requests via SystmOne. Improvements to our chasing processes for results that do not arrive requires improvement and will be reviewed by the Head of Healthcare."

7. The Primary Care Trust should refer Nurse A to the Nursing Midwifery Council for failure to clinically assess the woman on the 4 January 2012

   The National Offender Management Service accepted this recommendation, writing:

   "The referral has been made by the Head of Healthcare."

8. The Head of Healthcare should remind clinical staff that, when asked to review a prisoner, they should consult SystmOne to ascertain relevant medical history.

   The National Offender Management Service accepted this recommendation, writing:

   "The Head of healthcare will update the local Emergency Medical Response Policy to make this requirement clear. This policy revision will be communicated to Healthcare staff via a Notice and team briefings."

9. The Head of Healthcare should ensure that all emergency equipment, including suction equipment, is checked at least weekly. This should be documented.

   The National Offender Management Service accepted this recommendation, writing:

   "A recorded management check system will be established to ensure weekly checks."