

A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

**Investigation into the death of a woman at
hospital in January 2013, while a prisoner at HMP
Bronzefield.**

Our Vision

*'To be a leading, independent investigatory body,
a model to others, that makes a significant contribution to
safer, fairer custody and offender supervision'*

This is the report of an investigation into the death of a woman. She died in hospital in January 2013 while she was a prisoner at HMP Bronzefield. She was 44 years old. The provisional cause of death was that her organs failed because of a lack of blood supply due to a rupture in a major artery.

A clinical review was carried out on the woman's clinical care in custody. HMP Bronzefield cooperated fully with this investigation.

The woman was Romanian and spoke very little English. When she arrived at Bronzefield on 10 January her blood pressure was recorded as exceptionally high. No action was taken to monitor this or alert a doctor. She was discovered in pain and taken to hospital on 13 January. Her condition deteriorated and she died several days later.

The woman received a poor standard of care during her short time at Bronzefield. First, there was a failure to act on her high blood pressure reading the night she arrived. Indeed the clinical reviewer considers that, had she been admitted to hospital on the 10 January, the outcome might have been different. Second, when she was seen by a GP the next day, her high blood pressure had not been flagged on the computerised medical records. Even so, it is of considerable concern that the GP did not read her medical notes nor use a telephone translation service to communicate with her. He was, therefore, unaware, of the seriousness of her condition. Finally, when she was taken to hospital, she was unnecessarily restrained when clearly very ill, in pain and of little risk to the public.

Concerns regarding the standard of healthcare have been raised in a number of this office's recent investigations into fatal incidents at Bronzefield and also by Her Majesty's Inspectorate of Prisons. It is clearly essential that the Director and Head of Healthcare ensure that the lessons from this and previous investigations are learned.

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

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SUMMARY

1. The woman arrived at HMP Bronzefield on 10 January 2013 after being sentenced to three weeks in prison for theft, going equipped and breaching a previous conditional discharge. She was Romanian and spoke very little English.
2. During the first night reception process, a nurse carried out a health screen using a telephone translation service. He recorded an extremely high blood pressure reading of 237/143 but did not alert the on-call doctor, call an ambulance or arrange for her to be monitored.
3. The woman was seen the next day by the prison's GP as part of a general health check process. The doctor did not read her notes (which were on a computerised record) beforehand or use the translation service to help communicate with her. He did not notice the record of her high blood pressure.
4. On 13 January, a prison officer realised that the woman was in pain. He contacted a nurse who took observations. The nurse noted that her blood pressure was high (although not as high as before) and monitored her. When she continued to report pain and was sick, the nurse questioned her further using the telephone translation service. He decided that she should be sent to hospital for an assessment.
5. The woman was taken to hospital and found to be suffering from malignant hypertension.¹
6. Her condition continued to deteriorate and, on 15 January, the prison released her on a temporary licence. The prison contacted her family in Romania and some members of her family arrived at the hospital before she died.
7. This report makes five recommendations about the introduction of an early warning assessment tool, effective use of the computerised medical record system, the importance of healthcare professionals reading patients' notes and using telephone translation services where appropriate. We also make a recommendation about the proportionate use of restraints.

¹ severely high blood pressure and damage to at least one organ system

THE INVESTIGATION PROCESS

8. The Ombudsman's office was informed of the woman's death on 17 January 2013. The investigator issued notices to staff and prisoners informing them of the investigation and inviting anyone with any relevant information to contact her. No one came forward.
9. The investigator visited HMP Bronzefield on 22 January and spoke to the healthcare manager and two family liaison officers. She also spoke to the assistant controller and a representative from the Independent Monitoring Board. She obtained copies of the woman's prison and healthcare records.
10. A review of the woman's clinical care in prison was carried out by a clinical reviewer, a GP who specialises in primary care in secure environments.
11. The woman returned to Bronzefield on 18 March and 4 April, and interviewed eight members of staff. She also spoke to two prisoners on the telephone.
12. HM Coroner for Surrey was informed of the investigation and provided information about the provisional cause of death. The Coroner has been sent a copy of this investigation report.
13. The woman had family in Romania, including a daughter, and an English speaking friend in the United Kingdom. One of the Ombudsman's family liaison officers tried to contact the woman's friend but was unsuccessful. She wrote to the woman's daughter to explain the role of the Ombudsman and the purpose of the investigation, and to give her the opportunity to identify any matters she wished the investigation to take into account. The family asked us to consider the following:
 - Did the prison keep a medical record for her?
 - Was her blood pressure taken and if so, what was the reading?
 - Was she involved in any conflict at the prison?
 - When did she first feel ill and when was she taken to hospital?
 - Did the prison have its own hospital or was she taken straight to outside hospital?
 - Was she medically examined by anyone in the prison?
14. The woman's family received a copy of the draft report. They raised a number of questions that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

HMP BRONZEFIELD

15. HMP Bronzefield is a modern, privately managed prison for women, run by Sodexo Justice Services. It holds up to 527 women prisoners. It is a local prison, accepting prisoners directly from the courts. Most women are on remand or serving short sentences although it holds longer-term women prisoners including those serving life sentences. The GP contracted services are provided by Cimarron UK with Mental Health Services provided by the Central and North West London NHS Foundation Trust. The prison has a 24 hour impatient healthcare unit which accommodates up to 18 women.

Her Majesty's Inspectorate of Prisons (HMIP)

16. HMIP conducted a full unannounced inspection of Bronzefield in 2010. The Inspectorate found that the culture of the prison was positive and the physical environment clean and well maintained. However, inspectors reported that healthcare was an exception, the standard of service was described as "shockingly poor" saying that:

"Delivery was marred by poor organisation and inadequate staffing, both nursing and administrative; to meet the needs of women prisoners who were almost unanimous in their dissatisfaction with the quality of health services. A lack of liaison between GPs and with other healthcare staff meant there was little continuity of care ..."

17. Foreign national women represented almost 30% of the population. The Inspectorate considered that provision for such women was generally good. Staff were provided with information about specific vulnerabilities experienced by the group and issues were covered in the Equality and Inclusion Team meetings. An administrative officer was designated to provide support regarding foreign national issues and the inspectors considered that they demonstrated expertise. A representative from UKBA (Border Agency) attended the prison weekly.
18. The report noted that foreign national arrivals identified as not speaking English as a first language were given a pack with important information translated into a range of languages. Telephone interpreting services were used mostly in specialist areas such as reception and first night/induction unit. Officers often noted 'language barriers' on the wing file, but there was little evidence of what was done to address this. Foreign national women were less positive than others surveyed by the Inspectorate and, while they appreciated some of the excellent support they received, some felt isolated if they did not speak English.

Independent Monitoring Board (IMB)

19. Each prison has an Independent Monitoring Board of unpaid volunteers from the local community who monitor all aspects of prison life to help ensure that

proper standards of care and decency are maintained. The most recent IMB annual report for Bronzefield covers the year until July 2012.

20. The Board noted that the prison's management team had made serious efforts to address the inadequacies of the healthcare department in the past two years, but that significant concerns remained about the quality of healthcare provided to prisoners. The Board also said that foreign national prisoners said they felt well supported by the Equality and Inclusion Team.

Previous deaths in custody

21. There have been four deaths at Bronzefield in the past five years. The standard of healthcare has been raised in previous reports, and is raised again in this case.

KEY EVENTS

22. On 10 January 2013, the woman was convicted of theft, going equipped and breaching a previous conditional discharge. She was sentenced to three weeks imprisonment and sent to HMP Bronzefield.
23. When the woman arrived at Bronzefield, a nurse carried out a first reception healthscreen (this is designed to highlight any immediate health concerns). The nurse used 'Language Line' (a telephone translation service) to help him communicate with her. He recorded on SystmOne (the computerised medical record system) that she had an extremely high blood pressure reading of 237/143, but did not arrange for her to be seen by a doctor immediately or for any further monitoring. A routine appointment with the GP was made for the next morning.
24. The woman was taken to a holding cell and then to houseblock 1 (the induction wing), where she was given a single cell.
25. On 11 January, a doctor saw her. He had not been alerted to the extremely high blood pressure reading either verbally or by any of the special flags available on SystmOne.
26. The doctor did not use Language Line to communicate with the woman. He did not consider that there was anything physically or mentally wrong with her and recorded that she was a new reception who had arrived the day before, that there was no evidence of substance misuse, no medical or mental issues, she looked well and that no medical input was required.
27. A PCO (Prison Custody Officer) also saw the woman on the 11 January. He recorded that she seemed quiet, had trouble communicating as she spoke very little English and that he was going to arrange a move for her to houseblock 2 as there was at least one other woman on houseblock 2 who spoke Romanian. However, she would need to complete the third day of a four day induction process before she could be moved.
28. The PCO told the investigator that he arranged for one of the Romanian speaking prisoners to come over from houseblock 2 to speak to the woman in the meantime. He noticed that, while she was generally tearful, she seemed happier when chatting with the other Romanian woman.
29. On 13 January, the PCO was on duty waiting for the night staff to start their shift. The woman rang her emergency cell bell at approximately 5.50pm and the PCO went to see her. She indicated that she was experiencing pain in her chest and/or lower back area. The PCO asked a nurse to see her.
30. A nurse examined the woman. At 6.34pm he noted on SystmOne that she was restless and that her blood pressure 194/150 (which was still high). He gave her pain killers and planned to review her later. The PCO also said that he would keep an eye on her.

31. The PCO told us that the woman rang her bell again shortly after the nurse left her. She complained of the same symptoms and a pain in her arm. She was also being sick. The nurse came back but could not get a blood pressure reading. He took her to an office so they could use Language Line. A nurse's notes about this incident were entered on SystmOne at 7.45pm.
32. During the Language Line consultation the nurse established that the woman had chest and arm pains, difficulty breathing and backache. He decided that she should be assessed in hospital and an ambulance was called. An ambulance arrived at the prison at 8.35pm.
33. At 8.45pm, the woman was treated in the ambulance. She was escorted by two officers and restrained by an escort chain². Paramedics administered an electrocardiogram (ECG)³, to find out if she was having a heart attack. It is not clear from the records what the results of the ECG were. At 9.11pm, the ambulance left Bronzefield and arrived at hospital at 9.40pm. She was assessed in the Accident and Emergency department of the hospital and admitted to the hospital as inpatient at 1.40am.
34. At hospital, the woman was diagnosed with malignant hypertension (severely high blood pressure and damage to at least one organ system) and was given amlodipine (to treat high blood pressure). Scans showed a massive dissection of the aortic arch, the main artery to the heart had torn and its layers were peeling away. Clinicians decided against performing surgery as the damage was so extensive.
35. On 14 January, the woman was sick on various occasions throughout the day. She remained handcuffed to prison officers by an escort chain but this was removed for scans after the escort officers got the agreement of prison managers. Just before 5.20pm, escort staff were told that her condition was life threatening. They phoned the prison and permission was given for the restraints to be removed.
36. On 15 January at 7.15am, escort staff informed the prison that they had been told the woman was not to be moved and that there was little prospect of her recovering. It was then agreed that she should be released from prison on temporary licence and no longer escorted by officers.

Contact with the woman's family

37. On 15 January, two officers were appointed as prison family liaison officers (FLOs). FLO 1 contacted the Romanian Embassy at 5.20pm to ask if they would contact the woman's husband (who was in Romania) for them. Embassy officials said they could send police to speak to him.
38. However, at 6.03pm the FLO contacted him herself using the Language Line service. He told her that his wife had a heart condition and high blood

² A single handcuff is attached to the prisoner and a length of chain connects this to another worn by an officer.

³ A test to check the electrical activity of the heart

pressure. He also knew that she was in hospital as a prisoner. The FLO gave him the telephone number of the hospital. He said that their two grown-up children were aware of all the circumstances.

39. On 16 January, both FLOs visited the woman in hospital and spoke to her using Language Line. FLO 1 spoke to the woman's husband again and he told her that their children would be arriving that evening. She told the hospital and arranged to see the woman again on 18 January.
40. The woman's daughter and other family members arrived at the hospital during the evening of 16 January. Her condition continued to deteriorate and she died. Her family were with her. Both FLOs went to the hospital to see the family. A doctor explained the cause of death to her family. This was done via a Romanian nurse from the prison who had been asked to go to the hospital and help interpret.
41. The family liaison officers offered to help the family to arrange accommodation, but they had accommodation. The officers advised the family about arrangements for repatriating the woman's body.
42. Both FLOs stayed in contact with the family. They arranged a visit to the prison and assisted with repatriation documents. In line with national guidance, the prison contributed towards the cost of the repatriating the woman's body, including the transfer from the airport to her home village.

Support for staff and prisoners

43. A hot debrief was held on 17 January at 11.30am. Most staff who had been involved with the woman were invited but the officers who had escorted her at hospital were not included. However, the investigator spoke to some of the escort staff who said they had been offered appropriate support.
44. A notice from the Director informed prisoners and staff of the woman's death and appropriate support was offered if required. Prisoners who were considered to be at risk of suicide or self-harm were reviewed. The chaplain spoke individually to a prisoner who had known the woman.

Post-mortem Report

45. The Coroner has not yet provided a copy of the post-mortem report, but gave the provisional cause of death as multiple organ ischaemia and dissecting aneurysm of the aorta, this means that the woman's organs failed because of a lack of blood supply due to a rupture in a major artery.

ISSUES

Clinical Care

46. The woman was at Bronzefield only days before being admitted to hospital where she died from a ruptured aorta and associated complications. Her blood pressure was recorded as 237/143 at her reception health screen, which is very high. This should have prompted urgent action.
47. The clinical reviewer says that although the woman had a thorough reception and well documented health screen when she arrived at Bronzefield, there was no clear plan to deal with what was a potentially dangerous blood pressure reading. The nurse should have called the on-duty doctor or, at the very least, monitored her further.
48. The nurse who carried out the health screen said at interview that he had had a lot on his mind at the time and that he “might have intended to check on her [the woman] later as he would have been on duty on her houseblock”. However there is no evidence that he did this. The clinical reviewer says that it is possible that, if she had been admitted to hospital that night, the outcome might have been different.
49. The clinical reviewer says that, had the National Early Warning Score (NEWS)⁴ been used at Bronzefield, it would have flagged the need for urgent medical assistance when the woman’s very high blood pressure reading was noted.
50. Although the woman’s high blood pressure reading was noted, it was not flagged on SystemOne for any further evaluation or follow-up by the GP. The clinical reviewer indicates that there are a number of functions on the system which can be used to flag significant findings.
51. We raised our concerns about the actions of the nurse with the Head of Healthcare at Bronzefield. She has since informed us that the nurse has been spoken to about his actions and his line manager is working with him to provide support, training and management.
52. A GP saw the woman the next day. The doctor told us that he did not read the notes on SystemOne as the appointment was just one that happened as a matter of course. He said that all prisoners at Bronzefield had a GP appointment the day after their admission. He said he did not see the need to use Language Line to communicate with her and that the communication he had with her was “adequate”. We find this difficult to understand, as most other staff who spoke to her needed to use Language Line. We are not satisfied that the doctor or the woman would have fully understood each other. As she spoke very little English she would not have been able to

⁴ A standard guide used by clinical staff and emergency services to quickly determine the degree of illness of a patient. It is based on a number of physiological readings (including blood pressure, heart rate, respiratory rate, body temperature) and the level of consciousness, which are scored allowing an assessment of clinical risk.

explain to the doctor how she was feeling or answer any questions about her health. Communication was especially important as the doctor did not read her notes.

53. We accept that the GP had not been alerted to the woman's high blood pressure, either verbally or by a flag on SystmOne. However, we would have expected the doctor to read her patient notes from the night before to check there were no ongoing health problems, particularly because of the language difficulties. The clinical reviewer says that this would be in line with the General Medical Councils (GMC) Good Medical Practice guide. We make the following recommendations:

The Head of Healthcare should introduce the National Early Warning Score or similar assessment tool as part of any health screen, to ensure that a thorough assessment of clinical risk can be made.

The Head of Healthcare should ensure that staff highlight or flag issues on SystmOne that need evaluation or further follow-up.

The Head of Healthcare should ensure that the telephone translation service is always used when assessing patients with limited English.

The Head of Healthcare should ensure that all medical staff are aware of the GMC guidance on Good Medical Practice and read the available medical records when seeing a patient.

54. The draft report was shared with the doctor, who has since submitted an amended transcript.

Use of Restraints

55. The Prison Service has a duty to protect the public when escorting prisoners to hospital, and a responsibility to balance this by treating prisoners with humanity and maintaining their dignity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment which considers the risk of escape, the risk to the public, the prisoner's category and which also takes into account factors such as the prisoner's health and mobility.
56. A judgement in the High Court in 2007 made it clear that a distinction needs to be made between the risk of escape (and the risk to the public in the event of an escape) posed by a prisoner when fit and those risks posed by the same prisoner when suffering from a serious medical condition. The judgement indicated that medical opinion regarding the prisoner's ability to escape must be considered as part of the assessment process.
57. On 13 January, the woman was restrained by an escort chain in the ambulance when she was being assessed by ambulance staff. She remained restrained by an escort chain until the 15 January when she was released on temporary licence. Although records show the chain was removed when she

had scans, staff told us that for some of this period she was in a lot of pain and vomiting.

58. The woman was described as quiet and polite and was often emotionally distressed or experiencing pain. The escort risk assessments show all her risks as low. She had not been convicted of a violent offence and did not pose any particular escape risk. Her prison sentence was for only three weeks. In the circumstances we do not consider that appropriate consideration was given to her individual risk. We make the following recommendation:

The Director should ensure that escort risk assessments accurately reflect the prisoner's actual risk at the time and take account of a prisoner's medical condition.

Family issue

59. The woman's family asked whether she had been involved in any conflict while in prison. She was only in prison for a few days. We have examined the records and can find no suggestion that she was involved in any conflict with staff or other prisoners. Although distressed about her situation, she was described as quiet and polite.

RECOMMENDATIONS (Service response below in italics)

1. The Head of Healthcare should introduce the National Early Warning Score or similar assessment tool as part of any healthscreen, to ensure that a thorough assessment of clinical risk can be made.

Accepted: The clinical reviewer noted that a thorough health screen was undertaken at reception. However, it is recognised that a supportive assessment tool would further improve the robust screening process noted.

2. The Head of Healthcare should ensure that staff highlight or flag issues on SystmOne that need evaluation or further follow-up.

Accepted: Whilst the high blood pressure reading was noted on SystmOne for the doctor to read, the flag option was not used. Work has already commenced on refreshing staff awareness and training in this area.

3. The Head of Healthcare should ensure that the telephone translation service is always used when assessing patients with limited English.

Accepted: Although this recommendation is accepted as existing practice, we feel that the use of the telephone translation service is well promoted within the prison and we actively encourage its use for women who do not speak English.

This service is available for use by employees and contracted service providers, such as the GPs. Our monthly reports would demonstrate that this is a well-used service. However, it is for the individual to reflect on whether they can communicate effectively with a patient/prisoner to achieve their task. Where this cannot be done to their satisfaction, I would expect them to use the translation service available. In this case, the Doctor was satisfied that he was able to appropriately communicate with the woman.

4. The Head of Healthcare should ensure that all medical staff are aware of the GMC guidance on Good Medical Practice and read the available medical records when seeing a patient.

Accepted: This recommendation is accepted and has been communicated to the GP service provider.

5. The Director should ensure that escort risk assessments accurately reflect the prisoner's actual risk at the time and take account of a prisoner's medical condition.

Accepted: Whilst there was little known about the risk posed by the woman, as she was new to the prison, it is evident that her medical condition at point of discharge to the hospital should have indicated that mechanical restraints should not have been applied then or afterwards.