

**Investigation into the circumstances surrounding the
death of a woman
at HMP & YOI Eastwood Park in April 2010**

**Report by the Prisons and Probation Ombudsman
for England and Wales**

September 2011

This is the final report of an investigation into the circumstances surrounding the death of a woman in April 2010, whilst she was in the custody of HMP & YOI Eastwood Park. The woman, who was 42 years old, died at hospital as a result of an unexpected heart attack.

She had various symptoms which were attributed to asthma and shoulder pain. Tests had ruled out a heart condition. However, in April she asked staff for help because she felt unwell. She had vomited and felt hot and sweaty, with pains in her arms. The night nurse was just about to go off duty and handed the information to the day staff. They did not immediately go to see her and it was nearly an hour before they arrived. Whilst the nurses were assessing her, she suddenly collapsed and stopped breathing. An ambulance was called and cardio pulmonary resuscitation began. She was taken to hospital where the doctors tried for an hour and a half to save her life, but they were unsuccessful and she died at 10.25 am.

I would like to extend my personal condolences to the woman's family and friends for their loss. I apologise for the delay issuing my draft report in January 2011 and this Final report, and any additional distress this may have caused.

This investigation was carried out by my colleague. A clinical review, for which I am most grateful, was undertaken by a panel on behalf of the local PCT. I also thank the Governor of HMP & YOI Eastwood Park and her staff for their help during this investigation.

I have given considerable thought to the nurses' response to the call for help. The clinical review panel advise me that the delay was not detrimental to the outcome for the woman. Nevertheless, I encourage the Governor to consider the recommendations made by the clinical review panel.

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
Prisons and Probation Ombudsman

September 2011

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SUMMARY

The woman was sentenced to 28 months 25 days at Crown Court on 29 April 2009. She was initially taken to HMP Eastwood Park, but transferred to HMP Foston Hall a short time later. In September 2009, she returned to Eastwood Park.

She was being treated in prison by methadone detoxification for a long-term drugs problem. She did well on the programme and became drug free from 28 March 2010 onwards. She was well liked by both staff and prisoners within the prison. She was highly visible because she was an enhanced prisoner with the trusted job of cleaning one of the main corridors that run through the prison.

On the morning of 10 April 2010, she rang her cell call bell at 6.45 am. Staff attended and she asked to see a nurse as she had been sick and felt unwell. The prison officers contacted the nursing staff immediately, and day nurses eventually came to see her. They went to see other patients en route and arrived at approximately 7.40 am. As the nurses examined her, she collapsed and went into cardiac arrest. An ambulance was called and cardio pulmonary resuscitation began immediately. A defibrillation machine was used and an electrical shock was given to stimulate her heart, which proved to be quite successful.

The paramedics arrived and quickly transferred her to the ambulance and then on to hospital. She was breathing and her heart was beating, but she was unconscious and unstable. When she arrived at hospital she was taken into the accident and emergency resuscitation department where doctors tried to revive her for the next hour and a half. Unfortunately they were unsuccessful and she was pronounced dead at 10.25 am.

I am satisfied that the care and attention she received at Eastwood Park was equivalent to what she could have expected to receive had she been in the community. I do not think that her death could either have been predicted or prevented. Although I make no recommendations regarding the response by the nursing staff, it is a matter which has exercised me greatly during my investigation. I therefore urge the Governor and the local PCT to consider the implications of the recommendations made by the clinical review panel.

THE INVESTIGATION PROCESS

1. This investigation was undertaken by one of my investigators. He first visited Eastwood Park on 13 April 2010 and was given access to the woman's prison records. He saw the healthcare unit and the unit where she lived during her time at the prison.
2. During this initial visit, he met members of the Independent Monitoring Board (IMB), the prison chaplain and the Prison Officers Association (POA). He invited them to provide any information regarding the prison or the circumstances surrounding her death that they thought pertinent. Each prison has an Independent Monitoring Board. IMB members are unpaid and monitor day-to-day life in the prison to ensure that proper standards of care and decency are maintained. The IMB produces an annual report of its work. Neither the IMB, the POA nor the prison chaplain had any specific matters to bring to my investigator's attention at the time.
3. The investigator also ensured that Notices to Staff and Prisoners were displayed at the establishment, particularly in areas where she lived and worked.
4. The local PCT was asked to undertake a clinical review of the care that the woman received whilst she was in custody at Eastwood Park to establish whether she had received clinical treatment comparable to what she could have expected to receive had she been in the community. They appointed a clinical reviewer to lead a panel. The investigator asked the panel to consider particularly whether the prison health authorities had acted promptly in identifying her condition and whether there had been any delay in her treatment.
5. One of my family liaison officers contacted the woman's mother and father, as her next of kin, to explain the purpose of my investigation and to invite them to ask any questions or raise any issues for consideration. The family raised a number of questions and concerns and I hope this report addresses them and helps them better understand the events leading to their daughter's death. They took the opportunity to see and comment on the draft version of my report. Her father made the following observations:

He was not happy with some of the care she received whilst in prison. In particular he felt more should have been done to investigate the cause of her illnesses two or three weeks prior to her death. When she complained of being hot, sweating and having chest pains, she should have been sent to hospital for further tests. He also felt that her collapse on 14 March should have been more thoroughly followed up.

He told my office that he was very disappointed with the delayed response to her call for help on the morning she died. He believes the night nurse should have checked up on her herself, and not handed her care over. He feels that had this been done, she might well have survived. He made the point that had she complained of pains in her

arm in the manner she did, whilst at home, he would have called for an ambulance.

6. The Clinical Review team were contacted to allow them the opportunity to comment further on the woman's father's observations. They reiterated the fact that considerable efforts were made to revive her from 7.40 am until around 11 am and that staff were actually present when she collapsed. This might not have been the case had they attended earlier. I have no criticism of the efforts made to revive her and agree with the clinical review that staff being present at the time of collapse, gave her the best possible chance of survival under her circumstances.
7. The final matter he raised was linked to paragraph 24 in this report. He feels that it is inaccurate to describe her as an injecting drug user. It is fair to say that she was not a habitual injecting drug user, but she had used needles to inject drugs on one or two occasions only. The context of paragraph 24 is regarding the most usual way of contracting Hepatitis C. The most common way is through injecting drug use – but it is not the only method of contracting this virus.
8. The investigator contacted Her Majesty's Coroner to inform him of the nature and scope of my investigation and to request a copy of the post mortem report. Upon completion of this investigation, a copy of my report will be sent to the Coroner.

HMP & YOI EASTWOOD PARK

9. Eastwood Park is a closed local prison for adult women, young female offenders and juvenile girls. It was opened in March 1996 after refurbishment of the buildings which were previously occupied by male young offenders. It can hold 326 prisoners.
10. B wing, where the woman lived, is a small, refurbished self-contained area which is part of the original older construction. It has 43 spaces for women undergoing detoxification from substance misuse, mainly in double cells. It was opened in the spring of 2004.
11. In recent years population pressures meant Eastwood Park is predominantly a remand prison and the turnover of prisoners has increased considerably. The prison serves courts throughout the southwest, the south Midlands and the outer London catchment area. An overall reduction in the number of women's prisons in the United Kingdom means that often women are held more than 100 miles away from their homes.
12. Eastwood Park has a diverse regime offering courses in catering, horticulture, hairdressing, hygiene and beauty. It also offers sports leader and other sports awards, Job Clubs, offending behaviour programmes and educational courses ranging from basic literacy and numeracy to Open University post graduate degrees.
13. There is 24 hours healthcare provision which includes 12 inpatient beds. Many of the women coming into the prison have a history of drug use. They are identified by a variety of means including initial reception screening by healthcare staff, observations by other staff and self-referrals. Arrangements for detoxification, rehabilitation, treatment, education, counselling and educational classes are run by the CARATs team (Counselling, Assessment, Referral, Advice and Throughcare). Everyone who is identified as having a drug problem is assessed, given advice about their misuse, and referred to other services such as drug treatment programmes, housing, employment and external drugs intervention teams to prepare for their eventual release.
14. In October 2008 HM Chief Inspector of Prisons visited Eastwood Park on an announced visit. In her report she said:

"This is a positive report on a women's prison that, in spite of the considerable challenges, is performing reasonably well in all areas, and is carrying out some innovative and supportive work."
15. The Chief Inspector made specific comments in respect of healthcare services, describing them as being generally good, although she expressed some concern regarding the way medicines were managed. However, the survey of prisoners revealed that 81 percent thought that "the quality of healthcare delivered by nurses was good or very good".

16. Substance misuse services were also praised highly:

“The implementation of the integrated drug treatment system (IDTS) had resulted in an improved level of care for women requiring stabilisation/detoxification. The integration of services, the flexibility of treatment regimes and the quality of throughcare arrangements were impressive.”

17. The latest Independent Monitoring Board Annual Report, for the period 2008-2009, says that the Board was concerned about the dependence on agency nurses. They were, however, full of praise for IDTS within the prison.

KEY FINDINGS

18. The woman first arrived at Eastwood Park from court on 24 April 2009, after being sentenced at Crown Court for burglary. She was known to staff at Eastwood Park and settled in quickly. She had a long history of substance misuse problems but, apart from a chest infection, her health was otherwise good. She received antibiotics for her infection and was given methadone, an opiate substitute, for her substance misuse. On 28 April she was prescribed three inhalers to help with her breathing, although it was noted that she was smoking 20 cigarettes a day which would not help her condition.
19. She completed her initial induction at Eastwood Park. She originally lived on D wing then moved to B wing on 16 June. She was transferred to Foston Hall on 12 May, as part of her sentence plan, where she worked part-time on education and part-time in the prison gardens.
20. Throughout her time at Foston Hall, she was described as a pleasant and polite person, who needed reminding occasionally about some of the more simple wing rules, but otherwise was not a problem to staff. One of her personal officers, Officer A, wrote in her wing history report that she caused “no particular problems, other than she is often the last to work or to collect meals”. The officer also said that she enjoyed working in the gardens.
21. On 7 September, she moved back to Eastwood Park at her own request, to be closer to her family who lived in the south west. She had been working well at Foston Hall on her drug problems and was undergoing methadone detoxification. On 29 September, she was given the job of cleaning residential unit 1 (an area of the prison), a job which was relatively unsupervised.
22. She was made an enhanced prisoner under the incentives and earned privileges scheme (IEPS) on 29 September. IEP is a system to reward good behaviour in prisons. There are three tiers – basic, standard and enhanced, with enhanced being the highest level of rewards available. Incentives can include more visits, the opportunity to spend more private cash and the opportunity to have a bedroom to herself and not share with other people.
23. The same day she saw the doctor because she was unhappy about the pace at which her methadone doses were being reduced and was still having breathing difficulties. She was reassured on both counts by the doctor.
24. On 1 October, she was told that she had Hepatitis C. This was identified from blood tests arranged whilst she was at Foston Hall. Hepatitis C is a virus that causes inflammation of the liver. It is not currently curable, although the symptoms can be treated quite successfully with modern drugs. Not everyone shows any symptoms and people can have the disease for many years without it affecting them unduly, especially if they do not drink alcohol (which she did not). Hepatitis C is prevalent amongst injecting drug users. She was put on a waiting list for further treatment, including arrangements for on-going support in the community once she was released from prison.

25. Despite her generally good behaviour, she received warnings occasionally about relatively minor matters, although none affected her enhanced IEP status. For example, on 8 October she was warned about having excess bedding in her cell.
26. Her personal officer, Officer B, wrote in her wing history booklet on 10 October that she had six months still to serve and was preparing for her release. She hoped to open her own beautician business and wanted to take some relevant courses such as Indian head massage. She was also interested in being considered for voluntary drug testing in the prison.
27. She was seen by Nurse A on 8 November because she had fallen in the showers and bruised her elbow and thigh. Two days later, she saw the doctor because the pain had not gone and ibuprofen was prescribed. The doctor confirmed that there was no permanent damage to her elbow or thigh.
28. Another of her personal officers, Officer C (each prisoner at Eastwood Park has a main personal officer and a backup), wrote on 15 November that she had asked for home leave during the school Christmas holidays. The officer commented that she was doing well on the wing and would be considered for a move to another wing reserved for enhanced prisoners. This move seems to have happened later in November as her personal officers changed at this time.
29. She was seen by Prison Doctor A on 22 December because she said that her chest felt tight and she was short of breath. The doctor was of the opinion that she was having problems with her asthma, because of her poor technique when using her inhalers. The doctor advised her how to use her inhalers properly.
30. The next day she was seen again by the doctor, initially because she had a rash that Prison Doctor B thought was probably scabies. (Scabies is a skin condition caused by a tiny insect like mite. It is common in places where people live in close proximity to each other.)
31. Additionally, after prescribing a treatment for scabies, the doctor investigated pain which she reported in her shoulder and chest. He carried out an ECG (electrocardiogram which is an electrical trace of the heart). The ECG showed that her chest pains were not due to any current heart problems and so the doctor thought the most likely cause was her asthma. However, he made a note in her medical records that he thought that there was evidence of reduced blood supply to her heart which might be due to disease of her coronary arteries.
32. On 4 January 2010, she saw the doctor because of gynaecological problems and was given an appointment for ultrasound investigation at the local hospital. The appointment took place on 7 January and Prison Doctor B gave her the results four days later on 11 January. The ultrasound showed that

she had fibroids on her uterus. (Fibroids are benign [non-cancerous] growths in the uterus. They are common and usually cause no symptoms.)

33. Staff on her new wing (D wing) spoke with her a couple of times to warn her about her time keeping as she had been late leaving her wing on a few occasions when she should have gone to work. On 10 January, an officer wrote that she was doing well on her detoxification programme. She hoped to end the methadone detoxification within two weeks.
34. She felt dizzy on 14 January and was seen by Nurse B who took her blood pressure. This was normal and, as the dizziness soon passed, she was reassured and no further treatment was offered.
35. Prison Doctor B saw her again on 18 January because she had a tight feeling in her chest. She thought that she might be having a panic attack due to family worries. The doctor agreed with this explanation and advised her to use a technique to help control her breathing if the symptoms returned.
36. She was seen by Nurse C four days later with recurring symptoms of tightness in her chest. The nurse watched her use her inhaler and judged her technique to be poor. She gave advice on how and when to use her inhalers.
37. Also on that date, she was put on the bullying monitoring programme as another prisoner had accused her of bullying them. As there was no actual proof of bullying, she was allowed to keep her job and her enhanced status, but would be monitored by staff to check whether there was any foundation to the allegation. The monitoring stopped on 3 February as there was no evidence to support the allegation. On the same day, she was given a written warning about being late for work. Officer D, who wrote in the wing history sheet about the alleged bullying and her IEP warning, also wrote that she was "polite when spoken to even when given a warning".
38. During the next month she was seen a number of times by nurses and doctors because she found it difficult to come off methadone. However, after being reassured at each consultation, she continued with the planned reduction in the dosage.
39. On 8 March, she was given another written warning for being in a part of the prison where she should not have been. She was found in the toilets of the education department and should not have been there at the time.
40. She had an x-ray of her left shoulder on 9 March because she had fallen two weeks earlier and it was still hurting. No bone injury was found on the x-ray, but tramadol was prescribed to relieve the pain.
41. On the evening of 14 March, Nurse D was asked to see her because she said that her face felt strange. When the nurse examined her, she found that her mouth had "visibly dropped", although she did not have any other weakness in her arms or legs (which are signs of a stroke). The nurse spoke with Prison Doctor B who advised that she should be monitored every hour. The next

time the nurse visited her, she found her walking around her room with no apparent ill effects.

42. Later that night, at 2.40 am she woke up and was sick. She was seen by Nurse E who assessed her and reassured her. She wrote in the medical notes that there were no obvious signs of her mouth drooping.
43. She was seen two days later by Prison Doctor C who examined her and found nothing to explain what had caused her symptoms on 14 and 15 March. She did, however, review the medication she was receiving and alter several prescriptions.
44. On 18 March, she was suspended from her job cleaning residential unit 1, although no specific explanation was recorded in her wing history book. She was reinstated a week later because there was no evidence that she had been doing anything wrong, although staff were asked to keep an eye on her.

10 April

45. At approximately 6.45 am on 10 April, an Operational Support Grade (OSG) answered a cell call bell from her. She told the OSG that she had felt unwell during the night and had been sick. She now had pains in her arms and felt very hot. The OSG telephoned the nurse on duty for the night (the day staff had not yet arrived) and told the nurse that she was unwell.
46. Nurse F and a Health Care Assistant (HCA) arrived on duty 15 minutes later at about 7.00 am. They received a handover from the nurse, including the information about her being unwell. Both the nurse and the HCA then left the healthcare unit to go to see her, but they decided to check on some other prisoners first. Officer E went to see how she was and she told him that she was still unwell, so he used his radio to ask the nurses to go to the wing as soon as possible. At about 7.40 am, just as the nurse and the HCA arrived on D wing, they received a radio message to ask them to go to the wing.
47. When they arrived at her room, the door was unlocked by the officer. She was awake and was able to tell them what had happened. She said that she had vomited during the night and had felt strange and unwell ever since. She did not say when the pains in her arms had started, but she told the nursing staff that she felt hot and sweaty with tingling in her hands and arms.
48. The nurse attempted to take her blood pressure, but could not initially obtain a reading. She moved the machine to her other arm and took a reading of 119/48 with a pulse of 98 (that is a low blood pressure reading with a very fast pulse). At this point, she suddenly collapsed, stopped breathing and turned a blue colour.
49. The HCA left the room, collected the emergency resuscitation equipment and told the officers to call for an emergency ambulance. The nurse and HCA then started cardio pulmonary resuscitation (CPR). Another officer who was in the immediate area helped to move her and then withdrew from her room

as she was in a state of semi-undress. Instead he asked a female officer to help the nursing staff.

50. The nursing staff attached an AED (Automatic External Defibrillator) to her and this recommended that an electric shock should be administered. An AED is a portable electronic device that diagnoses heart rhythms after cardiac arrest. It is attached to the patient and advises whether an electric shock should be given. In her case, one shock was delivered and the AED advised staff to continue CPR.
51. The ambulance crew reached the prison at approximately 8.15 am and arrived at her bedside five minutes later at about 8.20 am. They took over CPR and quickly decided to move her to hospital. Prison staff arranged for two officers to accompany her. The ambulance left the prison at approximately 8.30 am on its way to hospital. As the ambulance crew left the prison, another rapid response paramedic arrived and he also got into the ambulance.
52. Throughout the journey, the paramedics continued to try to revive her, who was semi-conscious. She was unable to hear or respond to verbal instructions, but was breathing, albeit with some difficulty. They arrived at hospital at approximately 8.55 am and she was immediately taken to the resuscitation room in the accident and emergency department. Doctors continued to make strenuous efforts to save her, but sadly at 10.25 am she was pronounced dead.

ISSUES

Clinical care

53. The clinical review panel and I are satisfied that the overall care the woman received was equitable to that she would have expected to receive in the community. The clinical review contains the following comments regarding her general clinical care:
- “The woman appeared to have accessed the primary health care and Integrated Drug Service Team services appropriately. The team’s view was that this was more than comparable to primary care provision in the community.
- “She had been well supported in her wish to come off Methadone even though on occasions she had found this challenging and she had been successful in achieving this prior to her death.”
54. The panel particularly considered whether Prison Doctor B’s response on 23 December, after she complained of chest pain, was sufficient and appropriate. The clinical review panel commented that the resting ECG, carried out by the doctor, might not have entirely ruled out the possibility of any underlying heart disease. The prison doctors pointed out that she had a long history of shoulder pain, linked to falling, and they believed that there was no evidence to suggest that the pain was anything other than musculo-skeletal. The panel have not challenged this perspective and confirm that she was seen a number of times for shoulder pain.
55. The clinical review also points out that she spent many months taking a reducing dose of methadone regime, something that would inevitably lead to symptoms of vomiting, diarrhoea, headaches, cramps and night sweats at times. She worked hard to come off methadone and some of her visits to the doctors were because she found it hard to cope with the drug withdrawal. However, she persevered and on 27 March she had her final dose of methadone. The clinical review says that “it cannot have been easy to distinguish at all times if the presentation of some or all of these symptoms were attributable to another cause”.
56. The episode of facial weakness which she suffered on the night of 14 March initially gave me cause for concern as it seems from the records that she was not seen by a doctor until two days later on 16 March. However, the clinical notes clearly record that Nurse D consulted Prison Doctor B at the time and monitored her for any signs that her condition was worsening. I am satisfied that, if staff (or indeed the woman) had thought it to be an emergency, she would have been seen earlier. As it was, when she was seen on 16 March she declared that “she was better now” and thought that her problem had probably been due to a muscle spasm.

57. Although I make no recommendations myself in this report, the clinical review panel have made several recommendations. For completeness, I repeat those recommendations here:

1. That a more robust system should be implemented for reviewing patient records of previous attendances prior to a new consultation for GPs and nursing staff.
2. That healthcare staff arranging GP appointments for prisoners with specific physical complaints ensure that the reason for referral is recorded on the appointments slot within SystmOne, and that GPs access this information prior to consultation.
3. That relevant patient information recorded on handover sheets is transferred to patients' electronic patient medical records.
4. That temporary or locum healthcare staff have access to electronic patient records and computer systems with individual log in / password.
5. That healthcare staff do not log in for colleagues to update patients' records.
6. That staffing levels at night are reviewed given the geographical distances for staff to cover in response to both routine and emergency situations.
7. That healthcare staff receive adequate debriefing and support following emergency or traumatic incidents.
8. That healthcare staff on night duty are appropriately updated of any patient concerns following contact with healthcare during the day.
9. That there is a plan to reduce the number of agency registered nursing staff working at night to increase stability and continuity of care.
10. That a record keeping audit is carried out at least 6 monthly until the new electronic patient record system is embedded, then review annually.

Emergency response

58. The woman called for staff assistance at approximately 6.45 am. Night patrol officers alerted healthcare staff that she was having chest pains and had been sick. The night nurse was due to go off duty shortly and she handed the information about her over to the day staff. Although the degree of urgency conveyed to nursing staff is unclear from the medical notes, the indicative symptoms appear serious to me.
59. In an interview with my investigator, the OSG (who is not medically qualified) said that she told the nurse that the woman had “pains in her arms, she’s sweating profusely, she doesn’t look well”. The OSG went on to say that the nurse did not immediately reply, so she said “Are you coming over to see her or is this being passed over to day staff?” The OSG told the investigator that she thought that the nurse told her that she would “pass it over to day staff”. Had the nurse responded to the OSG’s call, it is likely that she would have been seen soon afterwards.
60. Nurse F and the HCA did not immediately go and see her after handover, and instead they went to see other patients within the prison. They made what the clinical review panel regards as a valid decision, prioritised by their knowledge of the patients requiring assistance, that she could be seen as soon as they could reasonably get to her. The nurses were not told that she required urgent attention, and they knew that their other patients had quite pressing needs. This resulted in nearly an hour passing before nursing staff saw her and, although that might seem unreasonable, it is the nature of non-urgent care in a busy clinical setting (whether in prison or in the community). The clinical review panel was not critical of this delay, saying that “under the circumstances, the delay in seeing her on the morning of 10 April was both understandable and justified, given the information available to the healthcare staff”.
61. It might ironically be this very delay in going to her which resulted in such prompt treatment being given when she collapsed and suffered a respiratory arrest. Had the nurses visited earlier, they may well have left by this time, and she been alone when she collapsed. Nursing staff were present at the moment that she collapsed and were therefore able to call for an emergency ambulance and start CPR immediately. The emergency equipment, including a defibrillator, was used very quickly with the result that she was partially revived. The clinical review says:
- ”The nursing team who attended her on the 10/4/10 were fully trained in life support techniques and were able to successfully resuscitate her and handover to a paramedic crew who escorted her to hospital.
- “Prison staff acted swiftly in ensuring her transfer out of the prison.”
62. Had the nurses attended more quickly, they might not have been present when she collapsed. If they had assessed her earlier, it is by no means certain that they would have recognised her symptoms as being cardiac in

nature and arranged transfer to hospital. She had been seen before for similar symptoms. She had complained of chest pains, collapsing, vomiting, panic attacks and pains in her arms and shoulders. On each of these occasions, nothing was recognised by any of the doctors or nurses which indicated that she was suffering with cardiac problems. Usually her symptoms were attributed to a panic attack or problems with her asthma. Only once did Prison Doctor B consider whether she might have cardiac problems. He arranged for an ECG to be carried out which did not show any heart related problems.

63. The post mortem revealed that she did indeed have a long standing cardiac problem and her cause of death was registered as:

- 1a. Acute Myocardial Ischaemia
- 1b. Chronic vasculitis of the right coronary artery

64. In lay persons' terms this means that her had a heart attack because one of the main blood vessels to the heart was severely affected by narrowing (the post mortem says it was 80 percent affected), due to inflammation or swelling of the walls of that vessel. The post mortem does not indicate for how long she had been suffering from this condition.

65. The clinical review panel confirm that she received the kind of care that she would have expected had she been in the community:

"The Clinical Review team findings were that given the nature of any personal illness of a prisoner is deemed personal and it does not appear to be normal practice for prison staff to question prisoners routinely when requests are made by prisoners to seek healthcare advice. This was reflected in the primary healthcare services and those interviewed acknowledged that appointments were predominantly prisoner led in terms of content. The panel confirmed that this reflects what occurs in community primary care."

66. As a lay person, my preference would have been for the prison nurses to have responded more quickly. However, I respect the findings of the clinical review panel regarding the particular circumstances of her collapse. Although I make no recommendations arising from her case, I hope that the Governor will look carefully at my report and consider whether there is any learning for prison and healthcare staff. In particular, prison staff will want to be certain that they accurately describe any symptoms (as they did on this occasion) so that healthcare staff have full information about the prisoner.

Substance misuse allegation

67. One of the features of the woman's life was her struggle with substance misuse. She had a long history of drug taking, but during this last sentence prison staff thought that she seemed determined to turn her life around. She worked hard at her detoxification and became free of all drugs shortly before her death. The clinical review panel examined this aspect of her overall

clinical care and found, as stated above, that she had been well supported in her wish to come off methadone.

68. After she died, one of the prisoners interviewed by the police provided a witness statement claiming that she had been taking drugs illicitly in prison before she died. One of the drugs in question was Quetiapine, which is an antipsychotic medication.
69. The post mortem report written by the pathologist on 13 July reveals that blood and urine samples were submitted to the Clinical Chemistry department at hospital for toxicological analysis. The Head of Toxicology at the hospital supplied a report on 5 July in which she recorded her finding that a number of drugs, including Quetiapine, were not found in her blood after her death. The only drugs found in her system were therapeutic levels of Mirtazepine (an anti-depressant medication she had been taking for a while) and tramadol, (which she had been taking as pain relief for some time). The scientific evidence is therefore that she had not taken illicit drugs.

CONCLUSION

70. The woman arrived at Eastwood Park in April 2009. Although she had a long history of drug use, she was determined to use her time in prison to cleanse her system of drugs and to lead a different life on release. She spent nearly a year on a drugs detoxification programme that eventually, and tragically just before she died, saw her free from illicit drugs. She was well liked by staff and prisoners who saw her regularly working in the trusted job of cleaning unsupervised in a busy area of the prison. She was an enhanced prisoner.
71. On the morning of 10 April 2010, she complained of feeling unwell and, although there was some delay in nursing staff seeing her, I am persuaded that this was not detrimental to her care. When nursing staff arrived, they started assessing her but almost immediately she collapsed and went into cardiac arrest. They quickly began CPR and an emergency ambulance was called.
72. When the paramedics arrived, CPR had been partially effective in that she was breathing and her heart was beating, albeit irregularly. Prison staff and paramedics quickly transferred her to the ambulance and then on to hospital. Doctors at the hospital tried for one and a half hours to revive her, but in the end they were unable to do so and she died at 10.25 am. She had a history of various symptoms which were attributed to asthma and falls. On one occasion the prison doctor considered whether she had a heart condition but tests ruled it out. I believe that, although the post mortem says that she did have a long standing heart problem, there were no symptoms which healthcare staff could reasonably have been expected to recognise. It follows that her death came suddenly and could not have been predicted or prevented.