PRISONS AND PROBATION
OMBUDSMAN
for England and Wales
Independent Investigations

A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a woman at hospital in March 2013, while in the custody of HMP Downview

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 investigation report into the death of a woman, a prisoner at HMP Downview, who died in March 2013 at hospital from pneumonia and associated sepsis. She was 46 years old. I offer my condolences to her family and friends.

A clinical reviewer conducted a review of the woman's clinical care in prison. HMP Downview cooperated fully with the investigation.

Ten days before her death, the woman was diagnosed with tonsillitis, which appeared to respond to antibiotic treatment. A week later, she reported being unwell and was taken to hospital where she was diagnosed with pneumonia and a possible lung infection. Her health began to deteriorate very rapidly and she died in hospital three days later. She had been a habitual drug user for many years before her imprisonment. While it is not possible to say for certain whether this affected the outcome when she contracted pneumonia, the clinical reviewer considers that her previous lifestyle was likely to have reduced her chances of recovery.

The investigation has found that the woman received prompt and appropriate medical care at Downview. However, I am concerned that the use of physical restraints was not justified by a fully considered risk assessment when she was seriously ill and taken to hospital.

Nevertheless, I am satisfied that, overall, the woman received good care at Downview. I also note that after her death the prison's family liaison officer made commendable efforts to trace, inform and support her family

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 **October 2013**

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SUMMARY

1. The woman was remanded into custody on 29 May 2012 and was subsequently sentenced to four years imprisonment. In prison, she was treated for heroin addiction and some short-term health conditions.

2. On 12 March 2013, the woman complained of feeling generally unwell, with a cough and headache. The nurse who examined her noted that her tonsils were extremely enlarged. A GP saw her later that day and diagnosed tonsillitis and prescribed a course of penicillin. A nurse checked her daily while she completed the course of antibiotics and her condition began to improve steadily.

3. On 17 March, the woman found blood in her sputum and the nurse arranged for her to see a GP on 19 March. Later that evening, she told the nurse that she had vomited a small amount of blood into her sink, so the nurse gave her an appointment to see the GP the following morning. The next day, she was too ill to walk to the GP's surgery 200 yards away and was assisted back to her cell. A nurse and a GP examined her in her cell and sent her to hospital by emergency ambulance.

4. In hospital, the woman's condition continued to deteriorate and she was moved to the high dependency unit. She was catheterised, a saline drip was used to restore her body fluids and a nebuliser was used in an attempt to regulate her breathing. The next day, doctors diagnosed that she had pneumonia and a possible lung infection. On 19 March, she was moved to the intensive care unit and placed on a ventilator to assist her breathing. The next day, a duty doctor told the escort staff that her lungs were beginning to fail.

5. A few days later the woman's kidneys also began to fail and she suffered a cardiac arrest. Hospital staff attempted to resuscitate her but were unsuccessful and she died a short while later.

6. Although the woman was in a poor physical condition and had been assessed as a low risk of escape and harm to others, a prison manager authorised the use of handcuffs and an escort chain while she was in hospital. They were removed to allow treatment but reapplied when she improved temporarily. Staff were authorised to remove them again while she was unconscious. The risk assessment was not reviewed to take account of her worsening condition.

7. The clinical reviewer concludes that prison healthcare staff treated the woman appropriately and we are satisfied that she received a good standard of medical care. After her death good efforts were made to contact her family. We make one recommendation about risk assessments for the use of restraints.

THE INVESTIGATION PROCESS

8. Notices were issued announcing the investigation to staff and prisoners at Downview, asking anyone with relevant information to contact the investigator. A member of staff and two prisoners came forward as a result.

9. The investigator visited Downview on 4 April 2012. He met the manager of the wing where the woman had lived and spoke to staff and prisoners. He obtained copies of her prison records, including her medical record. On 29 May, the investigator and a colleague interviewed three members of staff. On 6 June, the investigator returned to Downview to interview two more members of staff and a prisoner. He gave preliminary feedback on the investigation to the Governor.

10. The local PCT asked a clinical reviewer to review the woman's clinical care at the prison. He was given all relevant documents to assist his review.

11. The investigation report has been sent to the Coroner to assist his enquiries into the woman's death.

12. One of the Ombudsman's family liaison officers telephoned and wrote to the woman's mother to explain the investigation process and ask if there was anything that she wished to be considered. Although her family did not identify any specific issue for the investigation to take into account, they felt very strongly about the use of restraints and therefore welcomed our recommendation.

HMP Downview

13. HMP Downview in Sutton, Surrey, is a closed prison holding approximately 350 adult women. At the time of the investigation the prison also contained a seventeen bed facility, The Josephine Butler Unit, for girls under the age of 18.

14. Healthcare services are provided by Assura Medical Limited (a subsidiary of Virgin Healthcare). The healthcare centre is open from 7.30am to 8.30pm Monday to Friday and from 8.00am to 8.00pm at weekends. Each prisoner is allocated a named nurse to contact in the first instance about health matters. The aim is to encourage more women to use the healthcare facilities. Downview has no full-time GPs, instead the service is provided by Cheam Family Practice, Sutton, who also provide out of hours care. There are no inpatient beds at Downview.

HM Inspectorate of Prisons

15. HM Inspectorate of Prisons (HMIP) carried out a short follow-up inspection of Downview in September 2011. Inspectors found the prison had made good progress addressing the healthcare related recommendations made after the previous full inspection in 2008. Prisoners were generally positive about access to, and communication with, health services staff. However, while it was felt that prisoners had satisfactory access to a doctor, not all prisoners were aware that they could ask to see a female GP if they wished to. Wing-based administration of medication was identified as an area of concern.

Independent Monitoring Board

16. Each prison in England and Wales has an Independent Monitoring Board made up of unpaid volunteers from the local community who oversee all aspects of prison life to help ensure prisoners are treated fairly and decently. In its 2012 annual report the IMB reported favourably on the healthcare services at the prison. They were satisfied that the clinical needs of all prisoners were met.

Previous deaths at HMP Downview

17. We have investigated two deaths at Downview since 2004, of which one was from natural causes. Recommendations were made in those reports about record keeping, care pathways and the relationships between discipline and healthcare staff. There are no similar concerns in this report. (Since the woman's death there was an apparently self-inflected death in July 2013.)

KEY EVENTS

18. On 29 May 2012, the woman was remanded into custody by County Court charged with burglary and theft. She was taken to HMP Bronzefield. She was 45 years old and had previously been in prison.

19. When the woman arrived at Bronzefield a Staff Nurse carried out an initial reception health screen and noted that she was an intravenous drug user. She told him she was dependent on cannabis, cocaine and methadone (a prescribed opiate substitute) and had used heroin daily for approximately 12 years. She was immediately referred for drug treatment and prescribed methadone. She was reviewed frequently by the prison GP and monitored closely by prison healthcare staff.

20. During her time at Bronzefield, the woman was seen for gynecological and skin disorders but she often refused to attend routine clinics and appointments. She told a doctor at Bronzefield that she was confident that she would be released at her forthcoming trial, therefore the appointments were unnecessary. However, at her trial on 3 August, she was sentenced to four years imprisonment. She subsequently received two additional sentences to be served concurrently. She had little significant contact with healthcare staff in the following weeks.

21. On 29 October, after an altercation with other prisoners, the woman was transferred to HMP Downview. A nurse carried out a reception health screen in which she noted that she had been on a methadone maintenance programme at Bronzefield. A care plan was put in place to treat her drug dependency and this was regularly reviewed throughout her stay at Downview. The nurse noted that she had refused to attend a Well Woman Clinic appointment at Bronzefield. She made another referral for her to be seen at Downview but she subsequently chose not to attend.

22. As part of the reception process a GP assessed the woman's medical history and recorded that she was epileptic and her last fit had been on 27 October; she had developed a deep vein thrombosis due to intravenous drug use, for which she had been prescribed warfarin (an anti-coagulant to thin the blood and prevent blood clotting) and she had previously suffered from anorexia and occasionally continued to make herself vomit after eating. The doctor noted that she had been sectioned under the Mental Health Act 15 years previously.

23. Later that day, 31 October, a substance misuse nurse noted that the woman had been receiving a maintenance dose of methadone at Bronzefield. The nurse planned to continue that course of treatment, with a view to reducing her dependency in the future. On 2 November, the nurse reviewed her again to decide whether a mental health referral was necessary. She concluded that she would benefit from a referral, but there is no evidence in her medical records that any further action was taken.

24. Between November 2012 and January 2013, the woman had limited contact with healthcare staff. In January and February, a lump in her breast was investigated. On 28 February, a doctor recorded that no further intervention

was necessary as the lump had disappeared but during the examination, he noted that she had been suffering from back pain and migraines. The doctor prescribed medication for both issues and planned a further follow up appointment.

25. On 12 March, the woman reported to a nurse that she felt generally unwell and had a cough and headache. The nurse noticed that her tonsils were 'grossly enlarged'. The same day a doctor saw her and diagnosed tonsillitis and prescribed a course of penicillin. The nurse monitored her daily during the course of antibiotics and noted an improvement in her condition as the week went on. However, on 17 March, she reported blood in her sputum, so the nurse made an appointment for her to see the GP on 19 March.

26. Later that evening, the nurse examined the woman again after she reported vomiting a small amount of blood into her sink. As she had washed the vomit away, the nurse did not know whether or not it was fresh blood. The nurse gave her a specimen bottle to collect a sample of blood if there were any further occurrences and arranged for her to see the GP the following morning.

27. On 18 March, the woman, helped by a prisoner (who has subsequently died), set off to see the duty GP, whose surgery was on another residential unit some 200 yards away. An officer noticed she was having difficulty walking and helped her to return to her cell. As they got back to the cell, a nurse arrived to check if she had seen the GP as arranged. The nurse examined her and noted that her cough had become worse and her vital signs were low. She immediately started oxygen therapy to try and stabilise her, who was having difficulty breathing and contacted the GP for assistance.

28. The GP noted that the woman was unable to walk unaided or talk in complete sentences and, at 9.50am, requested an emergency ambulance. Her blood pressure dropped but she was stabilised before the paramedics arrived 9.55am. At 10.05am, the emergency ambulance left Downview and arrived at the hospital's accident and emergency department 25 minutes later.

29. As is standard practice, before the woman went to hospital, the prison carried out a risk assessment to consider the security measures required, including whether restraints were necessary. The assessment should include contribution from healthcare staff but this section was not completed. She was assessed a low risk on all aspects, including risk to the public, prison or hospital staff and risk of escape. The Head of Operations authorised the risk assessment. He instructed that two staff should accompany her, who should use single standard handcuffs for the journey and an escort chain in hospital. (An escort chain is a long chain with a handcuff at each end attached to the prisoner and an officer.)

30. The woman's condition worsened in hospital and, at 12.40pm, she was moved to the resuscitation unit. At 1.00pm, the escort officers asked for permission to remove her restraints to enable medical staff to treat her. The Head of Offender Management authorised this.

31. At 3.00pm, the woman was moved to the high dependency unit (HDU). She was in respiratory distress and required a nebuliser to regulate her breathing. (A nebuliser is a device to administer medication through mist inhaled into

the lungs.) She was catheterised and a saline drip administered to help restore her body fluid levels. At 7.40pm, her breathing had regulated and her condition improved slightly, although she remained seriously ill. The nebuliser was removed and oxygen therapy was started. The prison officers then re-applied the escort chain after they were told that her condition had improved.

32. On 19 March, during their morning rounds, doctors diagnosed that the woman had pneumonia and thought she might also have contracted a severe lung infection. At 10.05am, healthcare staff from Downview arrived at the hospital to obtain an update on her condition. A member of the chaplaincy team accompanied them, at the woman's request. She asked staff not to contact her nominated next of kin, but to notify her friend instead.

33. The woman was sedated and taken for a CT scan at 5.00pm. She was then moved to the intensive care unit (ITU), where she was placed on a ventilator (a machine to support breathing when patients cannot breathe on their own). At 6.25pm the escort officers contacted the duty governor, who gave permission for the restraints to be removed until she regained consciousness. At 7.30pm, prison staff contacted the woman's friend to notify him of her serious condition and admission to hospital.

34. On 20 March, the duty doctor told the escort staff that the woman's health was deteriorating and her lungs were beginning to fail. Her friend was given an update about her condition. She remained sedated and monitored by ITU staff.

35. At 7.00am on 22 March, nurses informed the escort officers that the woman's kidneys were failing and she might require dialysis. At 11.30am, the duty governor carried out a routine management visit, accompanied by the Head of Healthcare and another member of the Downview healthcare team. The duty governor spoke to one of the consultants responsible for her care and was told that her condition was deteriorating rapidly. He asked the prison's family liaison officer (FLO) to contact the woman's next of kin. The FLO and the deputy governor discussed the situation and felt it was "morally the right thing to do" to contact her nominated next of kin.

36. The chaplain went to the ITU, at 12.05pm, and said prayers for the woman. At 12.35pm, she suffered a cardiac arrest and hospital staff resuscitated her. At 2.00pm, the ITU doctor informed the duty governor that her kidneys were failing and there was nothing further they could do for her.

37. At the same time, the FLO, accompanied by another member of staff, went to the address recorded for the woman's next of kin, but they found that he had moved some years before. The FLO attempted to telephone him several times but was unsuccessful. The woman died at 2.25pm.

38. Over the next six days, the FLO contact various people named in the woman's prison and probation files. After extensive efforts, she discovered that she had a son and that her mother was alive, contrary to the information she had given staff at Downview. She obtained a telephone number for her

son but could not find an address. She therefore telephoned him on 28 March and informed him of his mother's death. He asked the FLO if he could tell his grandmother (the woman's mother) himself and she agreed.

39. The next day, the woman's mother telephoned the FLO to discuss her daughter's death and the arrangements for her funeral. The FLO continued to support the family throughout that time.

40. Downview held a memorial service for the woman on 17 April. The FLO arranged her funeral, which was held on 25 April and conducted by one of the chaplaincy team. Representatives from the prison attended and the prison paid the full cost.

41. A post-mortem examination established that the cause of the woman's death was klebsiella pneumoniae (a form of bacterial pneumonia) with associated sepsis (a life-threatening illness caused by the body overreacting to an infection) and lobar pneumonia (pneumonia affecting one or more lobes of the lung).

ISSUES

Clinical care

42. The clinical reviewer considers that the standard of the woman's healthcare was good. He noted that she had easy access to health services and that the arrangements for care on the wing meant that healthcare staff and prisoners were able to have day-to-day contact. In his opinion, her previous lifestyle choice probably contributed to her response to her final illness. Shortly before her death, hospital staff discovered that she was hepatitis C positive. She had declined testing for the hepatitis virus in prison. He comments that it is impossible to know how much the virus and the effects of her previous drug use contributed to her death but that the possibility could not be discounted.

43. The clinical reviewer concludes there were no shortcomings in the woman's care and management at Downview. He remarks that there was clear and accurate communication between the hospital and prison staff, who were fully aware of any changes to her condition. He considers healthcare staff did all that was possible and responded appropriately as the pattern of her illness progressed. We agree and are satisfied that her treatment and the handling of her medical care at Downview was prompt and appropriate

The use of restraints

44. 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 and which also takes into account factors such as the prisoner's health and mobility. 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 also indicated that medical opinion about the prisoner's ability to escape must be considered as part of the assessment process and that a fresh risk assessment should be conducted each time a seriously or terminally ill prisoner is moved or their clinical condition is reviewed in order to assess the appropriate level of restraint.

45. The risk assessment carried out for the woman's emergency admission to hospital on 18 March 2013, noted she was a low risk prisoner. Although it was clear that she was in extremely poor health and was to be accompanied by two prison officers, the risk assessment concluded that restraints should be used. The assessment did not include any healthcare input and was not fully reviewed and updated to reflect the changes in her health.

46. On 19 March at 9.10am, doctors informed the escort staff that the woman had contracted pneumonia and they suspected that she had also developed a severe lung infection. Her condition continued to deteriorate and at 5.53pm

she was moved to the ITU. At that point, she was fully sedated and her breathing aided by a ventilator. At 6.25pm, escort staff contacted the duty governor, for permission to remove her restraints. This was granted on the understanding that they be reapplied as soon as she regained consciousness.

47. We are concerned that the security risk assessment did not take into account how the woman's state of health affected her risk as the High Court judgement and subsequent Prison Service guidance requires. Although they were later removed, restraints were used while she was seriously ill and receiving life saving treatment. We therefore make the following recommendation:

The Governor should ensure that risk assessments for prisoners taken to hospital are completed fully, take into account individual circumstances, are updated regularly and are based on the actual risk the prisoner presents at that time. Unless there are exceptional circumstances restraints should not be used during life saving treatment.

Family liaison

48. The family liaison officer had a great deal of difficulty tracing the woman's family from the contact details in prison records. After considerable effort, she discovered that she had a son but she had to break the news to him by telephone as she could find no address. After their initial telephone conversation, she visited him and fully explained the circumstances of his mother's death. During the visit, she discovered that, contrary to what the woman had told the prison, her mother was still alive. After consideration, the prison agreed that her son should break the news to his grandmother. The FLO then visited the woman's mother and kept in regular contact, offering support and assisting with funeral arrangements. We consider that the efforts made by the FLO to trace the family and the support she gave to them were commendable.

RECOMMENDATION

The Governor should ensure that risk assessments for prisoners taken to hospital are completed fully, take into account individual circumstances, are updated regularly and are based on the actual risk the prisoner presents at that time. Unless there are exceptional circumstances restraints should not be used during life saving treatment.

Accepted. "The Governor has reminded staff that all risk assessments for prisoners at Downview who are taken to hospital should be completed as fully as possible. Risk assessments will record all the relevant information that is available and which has been taken into consideration when making a decision, while taking into account individual circumstances and ensuring this does not delay an emergency situation.

Downview will revise their local procedures and the guidance issued to staff to ensure that risk assessments are regularly formally updated and to clarify that, unless there are exceptional circumstances, restraints will not be used during life saving treatment.

Monitoring is now in place by the Head of Security and Operations on a monthly basis to ensure that this requirement is met.