



A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

**Investigation into the death of a woman at HMP
Eastwood Park in April 2014**

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, who died of ischaemic heart disease and aortic occlusion (blockage of the main artery) in April 2014, at HMP Eastwood Park. She was 53 years old. I offer my condolences to her family and friends.

A review of the clinical care the woman received at Eastwood Park was undertaken. The prison cooperated fully with the investigation.

The woman had been at Eastwood Park since 7 April 2014. She had a history of high blood pressure, a narrowing of the spinal canal and peripheral vascular disease (a build-up of fatty deposits in the arteries that restricts the blood supply to the leg muscles). She was underweight and had seen her community GP about significant weight loss.

On 22 April, the woman suffered with sickness and diarrhoea but made a full recovery. A few days later, a prison officer, conducting a roll check, saw she was lying awkwardly on her bed. The prison officer did not try to get a response from her, but noted she was breathing and thought she was asleep. Later that morning, an officer unlocking her cell could not get a response from her. Officers called for immediate medical assistance and a code blue emergency (indicating a prisoner is not breathing or unresponsive). Healthcare staff arrived quickly and administered emergency treatment, which paramedics continued when they arrived. The paramedics could get no response and confirmed that she died.

I am satisfied that healthcare staff at the prison could not have predicted or prevented the woman's death, which was from a sudden and devastating cardiac event. I agree with the clinical reviewer that the standard of care she received at Eastwood Park was equivalent to that she could have expected to receive in the community.

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. On 7 April 2014, the woman was sentenced to fifty-six days in custody for breach of a community order and assault. She arrived at HMP Eastwood Park that day. She had a history of high blood pressure, peripheral vascular disease and spinal stenosis and sometimes needed a wheelchair to get about.
2. The woman told the prison GP that she had lost over a stone in a short period and her community GP had taken investigatory blood tests. The GP requested her community medical records and arranged to check her weight again a week later, as she was significantly under weight.
3. The GP had information that the woman was dependent on alcohol and discussed her alcohol consumption with her. She did not have any physical symptoms of alcohol withdrawal, but spent her first two days in the Kinnon Unit (the prison's specialist drug and alcohol unit) for observation. She continued to show no signs of withdrawal and then moved to a ground floor cell on D Wing.
4. On 9 April, the woman's GP records confirmed that her blood results were normal. Because of her significant weight loss, the prison GP asked for further blood tests. The GP arranged to see her again on 16 April.
5. On 10 April, the woman declined help from the substance misuse team for alcohol dependency. On 16 April, she saw the GP and said that she believed her weight loss was likely to be due to stress. The GP prescribed build up drinks, weekly weight checks, laxatives and Zydol capsules for her back pain. On 17 April, she refused to go for investigative blood tests and said she would not attend any further medical appointments.
6. On 22 April, a nurse examined the woman in her cell when she was suffering from an episode of sickness and diarrhoea. By the next day, she had recovered.
7. A few days later, at 7.15am, an officer was carrying out a roll check to ensure that all prisoners were present in their cells. When he got to the woman's cell he noted that she was lying in an unusual position so watched her through the door observation panel to satisfy himself that she was breathing before he left.
8. At 8.40am that morning, an officer found the woman unresponsive in her cell. Officers made an urgent request for healthcare assistance and followed this up with an emergency code blue call. Healthcare staff attended and began cardiopulmonary resuscitation. The nurses gave her oxygen and applied the defibrillator, but there was no shockable heart rhythm. Paramedics arrived and continued emergency treatment until 9.53am, when they confirmed that she had died.
9. We are satisfied that staff at Eastwood Park could not have predicted or prevented the woman's sudden death. We agree with the clinical reviewer

that she received an appropriate standard of nursing and medical care at Eastwood Park. We make no recommendations.

THE INVESTIGATION PROCESS

10. The investigator issued notices to staff and prisoners at HMP Eastwood Park informing them of the investigation and inviting anyone with relevant information to contact her. One prisoner responded.
11. NHS England commissioned a clinical reviewer to review the woman's clinical care at the prison.
12. The investigator obtained copies of the woman's prison medical records and relevant extracts from her prison record. She interviewed six members of staff and a prisoner at Eastwood Park in July and subsequently interviewed three more staff by telephone. She wrote to the Governor with initial feedback about the preliminary findings of the investigation.
13. We informed HM Coroner for Avon District of the investigation who provided the cause of death. We have sent the Coroner a copy of this investigation report.
14. One of the Ombudsman's family liaison officers contacted the woman's family to explain the investigation process. Her family had a number of concerns and questions about her care at Eastwood Park, which we have taken into account in the investigation. These included:
 - Was she prescribed the correct medication, including sleeping tablets?
 - Was she assessed and did she have access to mental health support?
 - Did she have interventions to help her alcohol dependency?
 - Did she have appropriate facilities and accommodation for her disability?
 - Did she have any problems eating or drinking?
 - Why did the officer not try to get a response from her during the roll check?
 - What was the reason for the delay in being informed of her death?
15. The woman's family received a copy of the draft report and indicated that they were satisfied with the findings.

HMP & YOI EASTWOOD PARK

16. HMP & YOI Eastwood Park is a closed local prison holding about 360 adult and young adult women on remand or serving short sentences. There is also a mother and baby unit. Bristol Community Health provide healthcare services and Avon and Wiltshire Partnership Trust are responsible for substance misuse services.
17. The Kinnon Unit is the stabilisation unit for women with substance misuse problems. The unit holds 85 women and has 24-hour healthcare cover. Around 70% of the women entering Eastwood Park are admitted to the Kinnon Unit. The usual length of stay on the unit is two weeks.

Her Majesty's Inspectorate of Prisons

18. The last inspection of Eastwood Park was in November 2013. Inspectors found that the prison had made significant progress in providing treatment and support for the high number of women with substance misuse problems. The report found that the relationships between staff and prisoners were particularly strong, that healthcare services were good and women had thorough and timely care.

Independent Monitoring Board

19. Each prison in England and Wales has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community to help ensure that prisoners are treated fairly and decently. In its most recently published report for the year to October 2013, the IMB commented that there was still no overall head of healthcare, but this did not appear to have affected prisoner health. The Board praised the work of the Substance Misuse Psychosocial Team.

Previous deaths at Eastwood Park

20. The woman was the third prisoner to die from natural causes at Eastwood Park since 2010. There were no significant similarities with the circumstances of the deaths in previous cases.

KEY EVENTS

21. On 7 April 2014, the woman was sentenced to fifty-six days in prison for breach of a community order and assault. She arrived at HMP Eastwood Park that day. This was her first time in prison. At her reception health assessment she did not report any concerns about her mental health.
22. The woman's reception health screen identified that she had a number of chronic medical conditions, including high blood pressure, peripheral vascular disease and spinal stenosis. She scored highly on a substance misuse questionnaire and a prison GP saw her that day. She was significantly underweight and her body mass index (BMA) was below the healthy range. She said that she had lost over a stone recently and her GP had taken blood tests to investigate. She gave the GP a list of her prescribed medications.
23. The woman told the GP that she drank two cans of low strength lager each day, did not drink in the mornings and had no withdrawal symptoms. The GP had no concerns at the time, as her reported level of alcohol consumption was within national guidelines. The GP requested her community medical records and asked that her weight should be checked again a week later.
24. The GP saw the woman again later that day, after receiving information from the community mental health team, that she had been drink dependant since she was eighteen. She continued to deny excessive alcohol consumption and the doctor found no physical signs or symptoms of alcohol withdrawal. The GP asked staff to allocate her to the Kinnon Unit (the specialist drug and alcohol unit) for observation.
25. The woman did not show any withdrawal symptoms and moved from the Kinnon Unit after 24 hours. Because she had mobility problems, she moved to a ground floor cell on D wing. She had a walking stick and access to a wheelchair. A prisoner carer supported her, including helping her to the collect her medication from the medical hatch and attend medical appointments. (Known as pathway appointments at Eastwood Park.)
26. On 9 April, the GP received the woman's community medical records and confirmation of her medication, which she continued to prescribe. Blood test results taken in January 2014 had shown no abnormalities but, because of her weight loss, the GP asked for further blood tests.
27. On 10 April, a substance misuse worker offered the woman support and advice for alcohol problems. She declined any help and signed to say so. The substance misuse worker noted in the medical records that someone from the substance misuse team would go to see her in ten days to offer support again.
28. On 16 April, the GP examined the woman, who said that she had been eating well and thought her weight loss was likely to be caused by the recent stress of her court case. The GP prescribed build up drinks, with weekly weight checks, laxatives and Zyadon for her back pain. On 17 April, the woman

refused to attend for blood tests and said that she would not attend any further medical appointments. She did not explain why. Nevertheless, staff rescheduled the appointment for a later date.

29. On 22 April, the woman had sickness and diarrhoea and a nurse examined her in her cell. To reduce the risk of the spread of infection, she had to remain in her cell until the symptoms had gone. Healthcare staff treated her for dehydration. On 24 April, after remaining symptom free for forty-eight hours, she was able to leave her cell again.
30. A few days later, at 7.15am, an officer was carrying out a roll count to check that all prisoners were present on the wing. He noted that the woman was lying in an unusual position, with her hands by her collarbone and her legs off the bed. He told the investigator that it was not unusual to see prisoners in strange positions when they were sleeping and said there was nothing unusual about her cell. He said that he watched her and made sure she was breathing before he left. CCTV footage shows that he observed her through the cell observation panel for ten seconds before moving on.
31. At 8.40am that morning, an officer went to unlock the woman's cell. She first looked through the observation panel and noticed that she was lying awkwardly (apparently in the same position that the previous officer had observed.) She was concerned and went into the cell. She tried to rouse her but she did not respond. She shouted for help from a colleague, who was also unlocking cells at the time. He arrived at the cell within seconds.
32. An officer radioed the control room that immediate medical care was needed and an officer radioed a code blue emergency immediately afterwards. The control room contacted the healthcare centre for immediate medical assistance. When they received the code blue call, they immediately called an ambulance. Two nurses responded. The nurse who arrived first began to administer cardiopulmonary resuscitation while her colleague brought emergency equipment. She asked an officer to bring a defibrillator (a life-saving device that gives the heart an electric shock in some cases of cardiac arrest).
33. The nurses administered oxygen and attached the defibrillator, but it did not detect a shockable heart rhythm. At 9.05am, paramedics arrived and continued cardiopulmonary resuscitation, assisted by the nurses. The resuscitation attempt was unsuccessful and at 9.53 paramedics pronounced the woman dead.

Notifying the woman's next of kin

34. The prison's family liaison officer and an officer arrived at the woman's husband's home at 12.33pm, to break the news of her death. No one was home and they waited outside until 1.30pm when he returned. The family liaison officer informed him that his wife had died and offered her condolences and support. We are satisfied that the prison informed her husband of her death without undue delay.

Support for staff and prisoners

35. The prison issued notices to prisoners and staff informing them of the woman's death and offered support to anyone affected. A manager held a debrief on 26 April for the staff involved in her care and the emergency response to provide support and reassurance. The prison held a memorial service in the chapel on 27 April.
36. The funeral took place on 14 May. In line with national guidance, the prison contributed to the funeral costs.

Post-mortem

37. The post-mortem report concluded that the man had died from a very severe acute complication of aortic atheroma (accumulation of degenerative material in the tunica intima (inner layer) of artery walls) and of very severe coronary artery atheroma (hardening of the arteries) and ischaemic heart disease. The pathologist considered it unlikely that her recent gastrointestinal upset had contributed to her death.

ISSUES

Clinical Care

38. The clinical reviewer noted that the woman was known to have arterial disease, a history of intermittent claudication (narrowing or blockage in the main artery taking blood to the leg) and aorto-iliac disease (arteries become narrowed or blocked). He said that there were no symptoms of ischaemic heart disease and that she was on the most appropriate medication to treat high blood pressure and reduce the impact of arterial disease. She was not prescribed sleeping medication.
39. The woman was at high risk of cardiac disease and suffered a sudden devastating cardiac event that led to her sudden death, which healthcare staff at the prison could not have predicted. The clinical reviewer noted that she was on a good preventative regime, including medication, weight checks and blood tests. He concluded, and we agree, that her standard of nursing and medical care at Eastwood Park was equivalent to that she could have expected to receive in the community.
40. The woman was placed on the Kinnon Unit on arrival at Eastwood Park. She was monitored for alcohol withdrawal symptoms and moved to the ground floor of D wing the next day. She had the support of a prisoner carer and staff. We are satisfied that she was appropriately located in the prison.

Emergency response

41. During roll check, an officer noticed the woman sleeping in an unusual position. He watched her for several seconds to ensure she was breathing and left. He saw nothing unusual in the cell to cause him concern. The purpose of a roll check is primarily for security reasons to check that all prisoners are present and in their cells. It is not a welfare check, although officers should take action if they see anything untoward. He waited until he believed he saw that she was breathing and we consider he acted reasonably in the circumstances.
42. When two officers found the woman unresponsive, one called the control room for medical help. She should have called a code blue emergency medical code, which would also have alerted the control room to call an ambulance. However, an officer immediately rectified this and made a code blue emergency call. The control room then called an ambulance. We are satisfied that this did not cause any real delay. Nurses arrived at the cell quickly and administered appropriate emergency treatment.
43. The clinical reviewer was satisfied that staff managed the resuscitation attempt effectively and the ambulance arrived quickly. There was effective teamwork between the healthcare staff and paramedics.