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 HMP & YOI Eastwood Park in November 2013

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 at HMP Eastwood Park in November 2103. A post-mortem found that she died of a bacterial infection of the heart and a kidney infection, with methadone toxicity as a contributory factor. She was 34 years old. I offer my condolences to her family and friends.

A clinical review of the care the woman received in prison was conducted. The prison cooperated fully with this investigation.

The woman had a long history of substance misuse and associated ill-health and had been in prison before. She arrived at Eastwood Park on 13 November after being sentenced to four months in prison. She appeared relatively well until the date of her death. That morning, she did not collect her methadone maintenance medication and complained of feeling ill. A nurse went to see her but did not examine her or consider she was unwell, nor did she document the visit. Another nurse visited her shortly before 1.00pm and he too did not record the interaction or report it to healthcare colleagues, although he later said her pulse had been raised and she was incoherent. Later that afternoon, at about 4.00pm, an officer found her collapsed in her cell. Nurses attended and then called for the prison GP who asked for an emergency ambulance. Because of communication problems with the ambulance service, the call was not given high priority and paramedics did not arrive for about an hour. She was moved to the ambulance, but went into cardiac arrest and died.

Methadone toxicity was found to be a contributory factor in the woman's death. However, the reasons for the high level of methadone found in her body remain unclear. She had not taken any prescribed methadone that day and the investigation found no evidence that she had taken additional methadone from an illicit source.

The investigation has raised very serious concerns about the nursing care the woman received on 27 November, which may have resulted in her not being taken to hospital earlier that day. Bristol Community Health conducted disciplinary investigations into the conduct of two of the nurses who saw her on the day she died. One of them has since been dismissed for gross misconduct and reported to the Nursing and Midwifery Council and the other received a written warning and has since retired. I am satisfied that action has been taken, but there is a need for all nurses at the prison to understand their responsibilities to ensure that all the women receive appropriate care and that healthcare tasks are properly documented and recorded. I am also concerned that poor communication resulted in a delay in an ambulance arriving.

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 **September 2015**

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SUMMARY

1. The woman had a history of substance misuse and associated ill-health. On 13 November 2013, she was sentenced to four months imprisonment for failing to comply with the requirements of a community punishment order imposed for possession of a class A drug (heroin) and was taken to HMP Eastwood Park the same day. She continued a methadone maintenance programme she had been prescribed in the community and began a detoxification programme for benzodiazepines. She was allocated a cell in the prison's substance misuse unit, Kinnon Unit.

2. Towards the end of November, the woman did not collect her methadone in the morning. The manager of the substance misuse team went to collect her for a support group and found her unwell in bed. A nurse saw her immediately afterwards and later said that she did not appear unwell. She did not document her visit at the time or take any clinical observations.

3. The woman rang her cell bell at lunchtime and asked to see a nurse as she was not feeling well. The officer who responded telephoned the healthcare office on Kinnon Unit and another nurse went immediately to see her. The nurse took her pulse and then went directly to the lunchtime handover meeting. He did not document his visit to her or say in handover that she was not well. He later made an entry in her medical record that she had been incoherent and had a raised pulse when he had seen her at lunchtime.

4. At about 4.00pm, the woman's cellmate found her collapsed in their cell. She alerted an officer who called for the emergency response nurse. One of the prison GPs examined her and advised that she needed to go to hospital by emergency ambulance. Gate staff called an ambulance at 4.49pm, but as they were unable to give details of her condition, the ambulance was not prioritised. After a further call from the prison, an emergency ambulance arrived about an hour after the original call. Paramedics took her to the ambulance and continued to treat her, but she went into respiratory and then cardiac arrest. Despite a sustained attempt to resuscitate her, she was pronounced dead just after 7.00pm.

5. After disciplinary investigations by Bristol Community Health, the nurse who saw the woman in the morning was given a written warning. She has since retired. The nurse who saw her at lunchtime has been dismissed and reported to the Nursing and Midwifery Council.

6. A post-mortem examination concluded that the woman died from acute myocarditis (bacterial infection of the heart), pyelonephritis (kidney infection) and methadone toxicity. This investigation and a police investigation found no evidence that she had obtained illicit methadone at Eastwood Park.

7. We found that the lunchtime handover meeting for clinical staff was not properly recorded and it is not clear who had been tasked with actions arising from it. Poor communication meant that an ambulance did not arrive for over an hour after a doctor requested one.

THE INVESTIGATION PROCESS

8. The investigator issued notices about the investigation to staff and prisoners at HMP&YOI Eastwood Park inviting anyone with information to contact her. No one responded.

9. The investigator visited Eastwood Park on 3 December 2013 and met the Deputy Governor, the Clinical Services Manager and a representative from the Independent Monitoring Board. She collected copies of the woman's prison record and other relevant paperwork and interviewed her cellmate. She visited Kinnon Unit where the woman had lived.

10. NHS England (South West Team) commissioned a clinical reviewer to carry out a clinical review. The investigator and clinical reviewer jointly interviewed six members of staff. The investigator spoke to a further four members of staff by telephone. She gave feedback to the Deputy Governor and the prison liaison officer during the investigation.

11. The investigator liaised with the police investigating officer and with the Coroner's Officer. The investigator shared information with the police. She also spoke to an information governance officer at South West Ambulance Service Trust and an inspector from Her Majesty's Inspectorate of Prisons who inspected the drug and alcohol service at Eastwood Park in November 2013.

12. The investigator was told on 29 November that disciplinary investigations had been started into the conduct of two nurses who saw the woman on 27 November and agreed not to interview either nurse while the investigations took place. She was given copies of both investigations and the findings are reflected in this report. As a result of the findings of the investigations and the fact that both nurses were also interviewed by the police, we decided not to interview either nurse.

13. One of our family liaison officers informed the woman's mother and partner about the investigation. They said they would like to know more about the circumstances of her death. Her partner said he was concerned she had taken something before going to prison and that this had affected her health. He also asked if she had been given appropriate medication in prison.

HMP&YOI EASTWOOD PARK

14. 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 a separate juvenile unit and a mother and baby unit. Healthcare is provided by Bristol Community Health (BCH). Avon and Wiltshire Partnership Trust are responsible for substance misuse services.

15. Kinnon unit is the stabilisation unit for women with substance-misuse problems. The unit holds 85 women and has 24 hour healthcare cover. Nurses are available for continual observation and assessment. 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.

HM Inspectorate of Prisons

16. Her Majesty's Inspectorate of Prisons last inspected Eastwood Park in November 2013. Inspectors found that significant progress had been made in providing treatment and support for the high number of women with substance misuse problems. There was an excellent needs analysis accompanied by an effective drug and alcohol strategy. Prisoners with drug and alcohol problems had prompt access to an impressive array of treatment programmes. Psychosocial and clinical staff were co-located and communication between the teams was excellent.

17. The investigator spoke to the Deputy Head of Healthcare Inspection who inspected the drug and alcohol services. He confirmed that inspectors did not have any concerns about illicit methadone at Eastwood Park. He described the drug and alcohol services there as exemplary.

Independent Monitoring Board

18. 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. The IMB annual report for 2012 noted a concern that the cell safes on Kinnon Unit were not working properly and that naxolone (an antidote to opiate overdose) was not being supplied to women on their release because of cost. The IMB was also concerned that the waiting area for the primary healthcare centre was used to trade drugs.

Previous deaths at Eastwood Park

19. There have been six deaths at Eastwood Park since this office began investigating fatal incidents in 2004. Two of them occurred on the substance misuse unit. Other than that, there are no direct similarities between the circumstances of those deaths and that of the woman's.

KEY EVENTS

20. On 13 November 2013, the woman was sentenced to four months imprisonment for failing to comply with the requirements of a community punishment order imposed on 13 March 2013 for possession of a class A drug (heroin). She was taken to HMP Eastwood Park the same day. At her first night interview, she said she felt okay. She had been in prison before and had no immediate problems or concerns. She had a history of misusing heroin, benzodiazepines and mephedrone (an amphetamine known as MCAT or miaow miaow).

21. The woman's first reception health screen was completed by a nurse and a healthcare assistant. She did not show any signs of withdrawal from drugs or alcohol. She tested positive for opiates, methadone and benzodiazepines and negative for cocaine and amphetamines. She said she had taken her prescribed methadone and 40mgs of diazepam that morning. She said she did not need to see the GP until the next day. She was allocated a cell on Kinnon Unit, the prison's substance misuse unit. The nurse told her to press her cell bell if she needed anything.

22. The next day, 14 November, the prison received confirmation from the woman's pharmacy that she was prescribed 55ml of methadone daily and had received her supervised dose on 13 November. A GP saw her for her GP appointment at 9.27am. She told him that she sometimes used heroin on top of her prescribed methadone. He wrote that she spoke normally and made good eye contact. He put her on a four week benzodiazepine detoxification programme (reducing doses of diazepam daily) and continued her methadone prescription. He also prescribed metaclopromide (for nausea), paracetamol and peppermint oil (for the side effects of detoxification).

23. Later that morning, the woman told a manager in the Substance Misuse Psychosocial Team (SMPT) that she was too unwell for her scheduled assessment as she had been vomiting due to detoxifying and was finding it hard to wake up.

24. The woman had a secondary health screen on 15 November. She refused to have a blood test because she found it difficult to give blood.

25. On 16 November, the woman told a nurse that she had a history of deep vein thrombosis (DVT) and had been receiving clexane in the community. She said she had had a recent groin abscess and complained of swollen hands and feet. She saw a GP the same day. He examined her groin and prescribed antibiotics. She told him that she had been to hospital two weeks previously and they had planned to give her a leg scan but she had not had one. She said she had been on clexane for DVT. He could not find a reference to clexane (an anti-coagulant) in her GP notes, but prescribed daily injections and booked her for an ultrasound scan. She also asked for, and was given, an anti-inflammatory for shoulder pain.

26. On 18 November, the woman attended an assessment with a worker from the substance misuse team. The worker told the investigator that the woman said she was feeling much better and they talked for about an hour and a half. She described her daily drug use as half a gram of heroin injected into her arms or her legs, 30-40ml of illicit valium (diazepam – a benzodiazepine used to treat anxiety) and three and a half grams of MCAT. The worker said she was very engaged during the assessment and agreed to be referred to one of the substance misuse support groups for benzodiazepine users.

27. On 19 November, the woman complained to a nurse that her hands had been swollen for two to three weeks and had got worse over the previous few days. The nurse recorded that her fingers were swollen but her hands were warm and she had normal feeling in them. The nurse referred her to the GP.

28. A GP saw the woman on 21 November and noted that both her hands were puffy and painful, but she was otherwise feeling okay. When interviewed, the GP said that her hands were slightly swollen but her arms were not. She did not appear to be unwell, but she decided to refer her for a blood test. The GP said she was not sure why she had decided to do this but it was an instinctive response. She had her ultrasound scan that afternoon and the results showed no DVT. She subsequently refused to have the blood test that the GP had requested.

29. Prisoner A arrived at Eastwood Park on the same day as the woman. She told the investigator they became friends on Kinnon Unit and shared a cell for about five days before she died. She described her as pale and yellow looking when she arrived at Eastwood Park. She said she complained of stomach pain, difficulty sleeping and a bad back. She thought she became progressively more unwell. She did not think that these were symptoms of detoxification. She remembered her asking to see a GP, but thought this was about her foot.

The morning of the incident

30. Prisoners on Kinnon Unit are unlocked at about 8.00am for medication and breakfast. Prisoner A told the investigator that the woman did not get up for her medication on 27 November. She said she felt unwell, complained of a headache, was sleepy and stayed in bed. When the prisoner returned from breakfast, she had gone back to sleep. Between 9.15am and 9.30am, the substance misuse team manager went to collect her for a benzodiazepine support group. She said that the woman was sitting up in bed with the prisoner next to her. She told her she was not ready to go to the group. The manager asked her if she wanted a nurse to see her and she agreed. The manager told the investigator that she thought that she looked objectively unwell. She was wearing a nightdress and had a quilt around her. She looked pale and in discomfort and was leaning forward holding herself as if she was uncomfortable. She spoke as if she was in pain. The painful area appeared to be her stomach. The manager said she appeared quite unwell. She made a note in her substance misuse file. The prisoner said she left the cell to let her get some sleep.

31. Nurse A went to see the woman at about 9.40am at the manager's request and said she was sitting on the bed. She said she told her that she had missed her morning methadone medication because she had been asleep. The nurse said she was alert, able to answer questions and did not complain of feeling unwell or appear to be unwell. She looked pale but the nurse said that she did not know her so did not know whether this was normal for her. (The nurse had examined her on 19 November and referred her to the GP after she complained of swollen hands.) She said she had spent about two minutes with her and then left to do a clinic. She told her she would be able to have her medication at lunchtime. She did not take any formal clinical observations or record her conversation with her on her medical record or speak to any colleagues about it.

32. Prisoner A said when she returned to her cell after lunch she found the woman sitting up in bed rocking backwards and forwards and "passing out". She said the woman had been sick over the top of the toilet seat and looked like she had brought up bile. She said she told an officer that the woman needed a nurse and cleaned up the vomit.

33. An officer said she had answered a cell bell call from the woman's cell during the lunchtime patrol state (between 12.30pm and 1.30pm when the prisoners are in their cells) and spoke to her through the hatch in the cell door. She was lying on her bed in the foetal position and looked ashen. She told the officer she was in a lot of pain and asked to see a nurse. Prisoner A told the officer that she had been unwell for most of the morning. The officer said the woman was able to talk coherently.

34. The officer returned to the wing office and telephoned the nurses' office upstairs. She spoke to the Head of Healthcare and asked if a nurse could see the woman. Almost immediately she saw a male nurse walk down the stairs and go towards the cell. The nurse did not give her any report after he saw her.

35. The Head of Healthcare said that she had received a telephone call from the officer at about 12.00pm asking if a nurse could go and see the woman, who was complaining of stomach pains. She asked Nurse B to see her. In the statement he made after the woman's death, the nurse said he went straight to her cell. Prisoner A told him she was concerned about the woman, who did not seem to be herself that day. She then left the cell. She told the investigator that a nurse came to the cell and agreed that the woman did not look well but "didn't do anything".

36. Nurse B said that the woman was in bed when he went to see her and did not look any different to how he remembered her from seeing her on the unit. She was talking and did not complain of any pain. At his interview with Bristol Community Health, he first said that she was saying recognisable words but was subdued. Later in the interview, he said she was not coherent enough to obey simple commands. He said he took some observations. Her pulse was raised, but in his experience this was not unusual for a person with her history

of drug misuse. He said he spent ten minutes with her and was late for the lunchtime handover which started at 1.00pm. Prisoner A said that when she returned to the cell after the nurse had left, the woman was asleep again.

Lunchtime handover

37. All nursing staff on duty meet at about 1.00pm everyday for a lunchtime handover. Sheets are printed from SystmOne for all women on the acute substance misuse landing (the lower landing on Kinnon – Kinnon 1) and for any women about whom there are health concerns throughout the rest of the prison. Each member of staff gives a verbal report. The following account of the lunchtime handover on 27 November has been taken from interviews and statements made by staff during this investigation and the Bristol Community Health (BCH) investigations into the conduct of Nurses A and B.

38. Nurse A chaired the meeting. She said she fed back to the meeting that the woman had been sleepy and had missed her morning medication but did not write this on the handover sheet or any other record. One of the nurse managers remembered the nurse chairing the meeting and saying that the woman had not gone for her medication and was tachycardic (had a raised pulse), pale and tired.

39. Nurse B said in his original statement that he gave a verbal handover to about 15 members of staff. He was too late to complete the handover sheets which had already been printed. In his BCH interview, he said he handed over "bits and pieces" about the women he had seen that morning and he said words to the effect of "I have visited the woman, she has got a high pulse but otherwise seems okay". He said he did not handover that she was not speaking as well as she could. He said he felt his verbal report was not taken seriously.

40. A nurse remembered Nurse C reporting that the woman had not had her medication that morning and that she had been sleepy and in bed. She only remembered the woman being described as tired not unwell. She did not remember Nurse B being at the meeting. In her statement to BCH she said she thought Nurse C was going to check why she had not come for her medication.

41. Nurse C said at interview that Nurse B fed back that the woman was in bed not feeling well and colleagues told him that he should go back and see her again and that, if she was still unwell, to call the doctor. He added that she had missed her medication that morning and this also prompted colleagues to tell Nurse B to go back and check on her. He said that if a prisoner misses their medication in the morning, this is reported at lunchtime handover and a nurse is delegated to go and check on them. He said that the impression he got from Nurse B's description was that she had a cold. His memory was that Nurse B had been tasked to go and check on her again after the meeting, although this was not recorded anywhere.

42. A nurse remembered someone reporting that the woman had not collected her morning medication because she was sleeping and that this was out of

character. Another nurse said in a statement to BCH that she remembered either Nurse A, B or C saying that she had been sleepy and had not come for her medication that morning. She said that no medical concern had been raised about her.

The afternoon and evening of the incident

43. Prisoner A said she left the cell when it was unlocked before 2.00pm. When she returned, the woman was on the toilet complaining of stomach pains. As she got up she seemed disorientated and then went to sleep again. She left the cell again and when she came back later in the afternoon she found her lying on the floor by the toilet. She ran to the Kinnon Unit office and told an officer that the woman had had a fit and needed a nurse. The officer went to their cell and saw her lying on the floor. He said she looked pale, was breathing quickly and was not making any sense. He radioed for the emergency response nurse (call sign Hotel 1). When there was no response, he radioed the communications room and asked them to confirm that the nurse was aware of his call. He was told the nurse was on his way. He stayed with her and tried to make her comfortable. He said she tried to talk to him, but it was hard to understand what she was saying. After a while he became concerned that the nurse had not yet arrived and left the cell to try to find one. On the way he passed Nurse B (who was the emergency response nurse that day) and told him that she appeared to have had a fit and was breathing very quickly.

44. Nurse B said in his original statement that he received a call on the radio for Hotel 1 at about 4.00pm. In his entry on the medical record he noted that the call had been at 4.15pm. He found the woman on the floor of her cell. She responded to his voice and began talking. At his interview with BCH, he said that her speech was the same as it had been at lunchtime. He left the cell to ask a colleague for assistance. Prisoner A said the same nurse from the morning came to the cell and shook the woman to try to wake her. She said she came round but appeared disorientated. Her eyes were rolling and she had cracked lips from dehydration.

45. Nurse C said Nurse B had asked him for a second opinion. He said that the woman was lying on the floor of her cell in Prisoner A's arms. He described her as pale, disorientated and incoherent. Both nurses took observations. Her oxygen saturation was 100% and she was tachycardic (with fast or irregular heart rate). The nurses took her blood pressure with some difficulty as she struggled, but this was within the normal range. Nurse C told Nurse B he should ring for one of the prison GPs. Nurse C remained with the woman and tried to put her into the recovery position, but she continued to struggle and was incoherent. He was joined by another nurse. She said the woman was delirious, unable to obey commands, not alert and was unable to speak. The observations they managed to take were within normal limits.

46. A GP said that at about 4.30pm she was asked to go and see the woman. She reviewed her medical record and current medications first and could find no entry from earlier in the day which suggested that she had been ill. She

thought she arrived at the cell at about 4.40pm. When she got there, the woman was on the floor covered in a blanket being comforted by Prisoner A. Nurse C and another nurse were present. There is no time on the CCTV recording, but the GP arrived at the cell 27 minutes after Nurse B. The GP said it was obvious that she was very unwell. She was very pale with a fast heart rate and was breathing quickly. She was confused, mumbling incoherently and unable to answer any questions. The doctor asked Prisoner A whether she had taken any illicit drugs or too much of a prescribed drug. The prisoner said she had asked her the same question earlier in the day, but she had assured her that she had not taken anything. The GP asked the nurses to call an emergency ambulance and to give her high flow oxygen.

47. An officer said Nurse B telephoned the Orderly Officer and the gate and asked for a blue light ambulance. The woman was given oxygen and Nurse C said he tried to make her as comfortable as possible using a pillow and blankets, but she remained restless. He remained with her until about 5.20pm when he left to do the evening medication round. Nurse B and another nurse stayed with her. Nurse B said in his BCH interview that he asked for a blue light ambulance. He told the police that he phoned the orderly officer and asked for an emergency blue light ambulance. The orderly officer asked him to ring the gate. He said he rang the gate. He could not remember what exact words he used but said he conveyed that an emergency ambulance was needed.

48. Two operational support grades (OSG) were on duty in the prison gate area. OSG 1 took the call from Nurse B and immediately called the emergency services. OSG 2 recorded the time of the call in the communications room log book as 4.49pm. OSG 1told the investigator that Nurse B had asked her to tell the operator that the woman had an “HB/serious infection”. He told her that the operator would know what “HB” meant. She told the operator that the woman was breathing and the operator then asked a series of further questions. She explained that she was not able to answer them as she was not with her. The operator asked to speak to someone with the woman, but she said that was not possible as they were not near a telephone. The operator established that a healthcare professional was with the woman and said a colleague might call back for more information, but an ambulance would be sent anyway. The OSG told the investigator she had made a number of emergency calls before and the call followed the usual procedure. She believed that an emergency, blue light ambulance was on its way.

49. OSG 2 said in his statement to police that about 15 minutes after OSG 1had called 999, someone from the ambulance service, who he thought was a paramedic, called back and asked for more details. He told them that the doctor had requested an emergency ambulance, but the ambulance service operator asked to speak to someone who was with the woman. He said he then radioed Kinnon Unit, but was told all the nurses were busy treating the woman. He did not tell them that the ambulance service had asked to speak to a medical professional for further information. He said the person he spoke to said he would arrange for an ambulance to be sent.

50. The event chronology provided by South West Ambulance Service Trust (SWAST) shows that the emergency call was received at 4.50pm. The call was triaged by the operator using a computerised triage system based on the answers to questions about the patient's condition. The call was triaged as a category Green 4 which means an ambulance is sent with a response time target of within 60 minutes. The operator asked for a paramedic or nurse to call back to the prison for a more detailed triage of the woman's condition. The event chronology shows this took place at 4.55pm, but the categorisation of the emergency was not changed as a result.

51. The Head of Healthcare said she was told the woman that was not well and looked on SystmOne but could not find an entry that said she had reported feeling ill earlier. She went to her cell and asked Nurse B if she was the woman she had asked him to see at lunchtime and, if so, why there was no entry in her medical record. He told her the woman was the person he had gone to see earlier and he had forgotten to make an entry, which he would do later.

52. Nurse D went to the woman's cell to see if she could help. She said Nurse B told her, "I saw her earlier and I've just been told off for not writing up my notes from earlier on". She then advised him to go and write up the notes.

53. At 5.13pm, Nurse B wrote in the woman's medical record that he had seen her in her cell after a telephone call at 12.50pm. He wrote that she was in bed, "talking but mumbling incoherently". He recorded that her pulse at the time was 121 (normal range is 60-100) and her oxygen level was 99%. He said she was pale. He wrote, "plan: monitor for developments".

54. Nurse B made another entry in the woman's medical record at 5.17pm. He said he had attended her cell following a radio call at 4.15pm. He said she had deteriorated since he had seen her earlier, that the GP had been called and she had asked for a blue light ambulance. Oxygen was given. He described her as having "incoherent speech". At 5.38pm, he noted that they were still waiting for the ambulance.

55. When no ambulance arrived OSG 2 rang the emergency services again. He told them the GP had asked for a blue light. The operator told him that the ambulance was coming as an emergency and was ten miles from the prison.

56. The ambulance service event chronology shows that they received a second call from the prison at 5.37pm when the emergency was triaged as a category Red 2 (signifying a very serious situation but the patient is still breathing). An information governance officer at the ambulance service told the investigator that the distinction was that on this occasion the information received was that a GP had asked for an urgent response. The patient clinical record completed by the ambulance paramedics shows that they were mobilised at 5.38pm and arrived at the prison gate at 5.50pm. The ambulance was escorted to Kinnon Unit and the crew arrived at the woman's cell at 5.55pm. The patient clinical record completed by the crew described her as tachycardic (fast or irregular heart rate), tachypneic, (breathing rapidly)

agitated and delirious. Her blood pressure was low and she had pin point pupils.

57. Two officers were asked to escort the woman to hospital. Officer A said she was on the floor in the foetal position and thrashing about. Nurses were giving her oxygen and trying to keep the oxygen mask on her face. Officer B said her eyes were rolling and she could not stand up. She was not talking but groaning or mumbling incoherently. She was placed on a stretcher and strapped in because she was struggling. They left Kinnon Unit at 6.05pm.

58. Officer A said the level of escort had been set at two officers, that the woman should be restrained by an escort chain. At the time, her situation was not thought to be life threatening. Once she was in the ambulance he was cuffed to her with the escort chain. The paramedics tried to stabilise her and take some more observations. It quickly became obvious that the paramedics needed to continue treating her and both officers decided to remove the chain.

59. At 6.24pm, the woman went into respiratory arrest and the paramedics called for an emergency paramedic as back up. She went into cardiac arrest at 6.35pm. The additional emergency paramedic arrived at 6.40pm. A doctor was also called to the ambulance. Nurses, officers and the doctor assisted the ambulance staff with cardiopulmonary resuscitation (CPR) but they were unable to revive her.

60. At 7.06pm, the doctor confirmed that the woman had died. One of the prison chaplains said a prayer in the ambulance and paramedics moved the woman's body to the prison's chapel until it could be taken from the prison.

61. The Head of Security and Operations told the investigator that staff had asked the other women on Kinnon unit that evening whether they knew if the woman had taken any illicit substances. No one had seen her take anything. The Head said the women knew the seriousness of the situation and she believed they would have reported it if they had been aware that she had taken anything in addition to her prescribed medication.

Care for staff and prisoners

62. A hot debrief was held on Kinnon Unit for the officers and nurses involved. A member of the staff care and welfare team was present. The Deputy Governor also spoke to staff individually before they went home. Prisoner A was moved to a different cell. The women on Kinnon Unit subject to suicide and self-harm prevention procedure had their cases checked and reviewed in case they had been affected by the woman's death. All of the women on Kinnon Unit were given notices telling them about her death that night. The duty Listener (Listeners are prisoners trained by the Samaritans to offer confidential peer support) was also told. The women in the rest of the prison were told the next morning. A service for women on Kinnon Unit was held in the chapel at 11.00am on 28 November.

Family liaison

63. A custodial manager was appointed prison family liaison officer. The woman had named her partner as her next of kin. The police advised her that they should be present when news of the death was broken to him. She and an officer drove to South Wales that evening and broke the news to the woman's partner in person at his local police station. He gave them her mother's address and they went to her mother's house and broke the news to her. The prison offered a financial contribution to the funeral in line with national guidance. The custodial manager remained in contact with both the woman's partner and mother.

Post-mortem and toxicology reports

64. A post-mortem report gave the woman's cause of death as:

> "1a acute myocarditis (bacterial infection of the heart) and pyelonephritis (kidney infection) and
> 2a methadone toxicity."

On the issue of the levels of methadone in the woman's blood, the pathologist concluded, "This is a concentration by which itself could potentially cause serious toxic effects and is significantly higher than would be expected if she had simply been following her treatment regime. It is true that methadone does have a long half life but her prescribed dose and bodyweight suggest that the prescription by itself could not have produced such a level. The possibility exists therefore that she had managed to obtain additional methadone from another source". The pathologist said that the presence of both myocarditis and pyelonephritis suggested a systemic infection that would have increased her need for oxygen and made her more vulnerable to the potentially toxic effects of methadone.

ISSUES

General clinical care

65. The clinical reviewer noted in his clinical review that he had serious concerns about the events of 27 November. However, he reported that the clinical care given to the woman before then had been of a good standard and equivalent to that available in the community.

The actions of nursing staff on 27 November

66. The Clinical Services Manager said that, when someone misses a methadone maintenance dose, she expects the nurse administering the medication to investigate the reason why the dose was missed when they finish the medication round. The nurse administering the medication on the morning of 27 November was Nurse C, but he did not go to see the woman to establish the reasons why she had not collected her methadone. In the event, Nurse A went to see her that morning at the request of the substance misuse manager who was concerned that she did not appear well, but no one went as a matter of routine because of the missed dose. We make the following recommendation:

The Clinical Services Manager should ensure that the nurses administering methadone on the Kinnon Unit investigate the reasons when prisoners do not attend to collect it.

67. After a serious incident such as a death in custody the healthcare manager is required to undertake a review within 72 hours of the death. The Clinical Services Manager and a doctor completed their review on 30 November. They recommended that the conduct of Nurses A and B be investigated by Bristol Community Health (BCH). The Clinical Services Manager suspended Nurse B pending the investigation. BCH found that Nurse B failed to act appropriately following his assessment of the woman at 12.50pm. He had identified that her pulse was not within normal ranges and that she was incoherent, but failed to report this to the clinical team when they met at 1.00pm and to request an emergency consultation with the GP. BCH also found that he had not entered his assessment on to SystmOne in reasonable time. BCH recommended that Nurse B face a formal disciplinary hearing. The disciplinary hearing found him guilty of gross misconduct, dismissed him from his job and referred him to the Nursing and Midwifery Council. We agree that he did not provide the expected standard of care when he saw the woman and failed to record and explain his actions and decisions in the medical record at the time.

68. The BCH investigation of Nurse A found that she did not carry out any observations of the woman, or make a thorough assessment, or take a history when she saw her at about 9.30am on 27 November. The investigation also found that she did not make a written record of the intervention and did not access the woman's medical record to check her history at any time. The investigation concluded that formal observations might have identified an

increase in her pulse throughout day (although Nurse B did not check SystmOne either, so he would not have seen this). A subsequent disciplinary hearing issued Nurse A with a written warning about her conduct. She has since retired.

69. The clinical reviewer contacted a specialist in A&E medicine at Bristol Royal Infirmary. The specialist said that, from an examination of her notes, it appeared that the woman had been extremely ill when she was reviewed late on the morning of 27 November. The specialist added that, had she been sent to hospital at that stage, she would almost certainly have gone into the resuscitation unit for IV fluids, high flow oxygen and possibly IV anti-biotics, as well as blood tests. While it is impossible to know if she would have survived, the additional four hours would have allowed for stabilisation and a working diagnosis to be developed. She would also have been in a better place for any resuscitation effort.

70. We are satisfied that the Clinical Services Manager and BCH took prompt action in respect of both nurses, but we are concerned about their actions on the day. We make the following recommendation:

The Clinical Services Manager should set out clear clinical standards which require all healthcare staff to assess patients appropriately when there are concerns about their health, take and record observations as required and record actions and decisions about their ongoing care in their medical records at the time.

Healthcare handover meeting

71. Eastwood Park holds a lunchtime handover meeting to provide the clinical team with updates on all women on the acute substance misuse wing (Kinnon 1) and about any women in the rest of the prison whose health is causing concern. All clinical staff on duty attend the handover, give verbal reports and also write on the handover sheet. The handover sheet is on SystmOne and can be updated at any time. A copy is printed for each new shift.

72. It is clear from our enquiries and the BCH investigations that the woman was mentioned at the lunchtime handover on 27 November. However, it is not clear who raised her case, what they said or what future actions were agreed. We found the handover record difficult to follow: it did not include details of who attended and what decisions were made. The Clinical Services Manager told the investigator that she would have expected Nurse B to report verbally at the meeting and then make an entry in the woman's personal medical record and the handover document on SystmOne. We are concerned that appropriate records were not kept which made it clear who was responsible for follow up actions with patients discussed. We make the following recommendation:

The Head of Healthcare should ensure that attendance, discussion and actions, including the person responsible for each task, are accurately recorded and followed up at healthcare handover meetings.

Emergency response

73. A medical emergency response radio code was not called when the woman's condition deteriorated on the afternoon of 27 November. This is understandable as it was not immediately apparent that this was an emergency situation. Nurses attended quickly and attempted to take her observations. However, as soon as the doctor arrived she recognised the gravity of the situation and asked Nurse B to call the communications room and request an emergency ambulance.

74. An emergency ambulance was first called at 4.49pm, but paramedics did not arrive at Eastwood Park until 5.50pm. The delay appears to have been caused because the call was triaged as a lower level priority, based on the information available to the staff in the prison's communications room. The ambulance operator asked to speak to someone who was with the woman but was told that this was not possible. Only when OSG 2 rang back and told the operator that a GP was with the woman and had asked for an emergency ambulance was one dispatched as a priority

75. When the doctor saw the woman she was clearly gravely ill and it is not possible to say whether the delay in paramedics arriving would have changed the outcome. Nevertheless, the delay is a matter of concern. Prison Service Instruction SI 3/2013 requires prisons to have emergency response protocols and paragraph 5.5 states that, "As the logistical and operational arrangements of each prison will differ, the terms of medical emergency protocols must be written and agreed in conjunction with the local healthcare commissioner and the local ambulance trust". It is important that prisons discuss the handling of emergencies with their local ambulance service so that they have a clear understanding of the prison context and that it is not always possible for healthcare staff treating the prisoner to speak to the ambulance service directly. We make the following recommendation:

The Governor and the Head of Healthcare should agree a protocol with South West Ambulance Service Trust to ensure they understand the prison context and that staff who request ambulances might not have immediate detailed information about the patient.

Methadone toxicity

76. The post mortem examination and toxicological tests found a higher level of methadone in the woman's blood than could be explained by the amount of methadone prescribed for her at Eastwood Park. While we cannot rule out the possibility that she had concealed methadone when she arrived there is little indication that this was the case. Neither this investigation nor that conducted by Avon and Somerset Police found any evidence that she had obtained illicit methadone while in Eastwood Park. The prison had received no intelligence about diversion of methadone and Prisoner A, her cellmate, told the investigator she did not think she had taken anything illicit. Other women on Kinnon Unit agreed with this when they were asked on the evening

of her death. On the day she died she had not taken the methadone she was prescribed and the clinical reviewer found that there was no indication that symptoms were missed or that any issues were developing.

77. A recent inspection of the drug and alcohol services at Eastwood Park by HM Inspectorate of Prisons found that the processes for administering controlled drugs were sound. In a statement to the police the Head of Security explained that women are only fully searched on arrival in prison if there is intelligence or reasonable suspicion that they are concealing an item that would be revealed by the search. The woman was not subject to a full search when she arrived at Eastwood Park two weeks before she died. We are satisfied that there is no evidence of a widespread problem with illicit methadone at Eastwood Park.

RECOMMENDATIONS

1. The Clinical Services Manager should ensure that the nurses administering methadone on the Kinnon Unit investigate the reasons when prisoners do not attend to collect it.

2. The Clinical Services Manager should set out clear clinical standards which require all healthcare staff to assess patients appropriately when there are concerns about their health, take and record observations as required and record actions and decisions about their ongoing care in their medical records at the time.

3. The Clinical Services Manager should ensure that attendance, discussion and actions, including the person responsible for each task, are accurately recorded and followed up at healthcare handover meetings.

4. The Governor and the Clinical Services Manager shall agree a protocol with South West Ambulance Service Trust to ensure they understand the prison context and that staff who request ambulances might not have immediate detailed information about the patient.

ACTION PLAN

No	Recommendation	Accepted/Not accepted	Response	Target date for completion	Progress (to be updated after 6 months)
1	**The Head of Nursing should ensure that the nurses administering methadone on the Kinnon Unit investigate the reasons when prisoners do not attend to collect it.**	Accepted	A local policy has now been implemented with clear pathways (i.e. action to be taken) for prisoners not attending for collection of methadone/buprenorphine. The local policy also informs clinical decision making about continued methadone administration that day and gives clear guidance to nurses on when to contact a doctor for further review and inform other relevant staff working in substance misuse. The local policy requires nurses to record on SystmOne (the clinical IT system) that they have seen the non attending prisoner and recorded their reasons for not attending to collect their medication.	Complete Ongoing audit of records.	
2	**The Head of Nursing should set out clear clinical standards which require all healthcare staff to assess patients appropriately when there are concerns about their health, take and record observations as required and record actions and decisions about their ongoing care in their medical records at the time.**	Accepted	An assessment template on SystmOne has been developed and implemented which will allow nurses to record all presenting signs and symptoms and clinical observations for assessment of prisoners in cell or out of hours. Decisions about care are clearly recorded and evidenced in SystmOne records. Arrangements are in place to ensure audits of SystmOne records are completed to check that effective record keeping is in place. All healthcare staff are expected to be able to show evidenced records of clinical supervision and clinical update training. A cohort of nurses will in due course receive specialist training in long term conditions and	Complete Ongoing – record keeping audit scheduled for Oct 14. Ongoing	

			other specialist areas, including diplomas in Diabetes, Asthma, Chronic Obstructive Pulmonary Disease and Respiratory Disease.	December 2014 – March 2015	
3	**The Head of Nursing should ensure that attendance, discussion and actions, including the person responsible for each task, are accurately recorded and followed up at healthcare handover meetings.**	Accepted	The Head of Nursing has reminded nursing staff, both verbally at staff meetings and via email, that those on duty must attend the handover meetings and the Senior nurse is to be present at all handovers. Clear handover records are expected from all staff, and responsibilities for specific actions are now assigned to a named nurse.	Complete	
4	**The Governor and the Head of Healthcare shall agree a protocol with South West Ambulance Service Trust to ensure they understand the prison context and that staff who request ambulances might not have immediate detailed information about the patient.**	Accepted	Since the Governor met with the Health and Justice Commissioner NHS England about this matter, arrangements have been made to meet with the Commissioner for South West Ambulance service to discuss the development of a prison specific algorithm to expedite the request for an Ambulance.	30th Sept 2014	