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 in June 2014, while in the custody of HMP &YOI Eastwood Park**

## *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 a perforated intestine, due to Crohn's disease in June 2014. She was 31 years old. I offer my condolences to the woman's family and friends.

An investigator carried out the investigation. A clinical reviewer reviewed the clinical care the woman received at Eastwood Park. The prison cooperated fully with this investigation.

The woman had been at Eastwood Park since 17 March 2014. She reported no significant health problems until 15 May, when she said she was suffering from migraines. On 26 May, another prisoner told an officer that the woman rarely left her cell and was not eating. The woman developed severe sickness and diarrhoea. Nurses visited her and noted how thin she was. A nurse referred the woman for a GP appointment and for weight monitoring on 28 May, but the woman did not attend. On Sunday 1 June, a nurse weighed her and realised she had lost three stone since she had arrived. The nurse reported this immediately to an out of hours GP, who asked for urgent blood tests. Later that night, staff found the woman lying on the cell floor. A nurse noted that her clinical observations were all within the normal range and that the woman was due to see a GP the next morning.

The GP arranged for her to be admitted to hospital for treatment, but that afternoon, the woman collapsed and lost consciousness and was taken to hospital as an emergency. On 4 June, the hospital diagnosed that it was likely that the woman had Crohn's disease. The woman's condition appeared to improve a little, but on 6 June, the woman's intestine suddenly perforated and she died.

The clinical reviewer noted that the woman had a very rare clinical presentation and that her death was sudden and unexpected and could not have been avoided. The clinical reviewer found that the woman's primary care at the prison was largely equivalent to that available in the community, but tended to be reactive. He noted a need for all staff at the prison to be vigilant and act on significant physical changes which might indicate a concern. I am concerned that the prison took too long to inform the woman's family that she was in hospital and that the use of restraints in hospital was not justified on security grounds.

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** **March 2015**

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## SUMMARY

1. On 17 March 2014, the woman was remanded to HMP Eastwood Park and later sentenced to six months in prison for handling stolen goods. At her initial health screen, she weighed 11 stone. The woman continued a methadone maintenance programme, which she had been prescribed in the community.

2. From 15 May, the woman began to complain of migraines. She stopped eating and towards the end of May began to suffer from vomiting and diarrhoea. Healthcare staff made appointments to investigate her symptoms, but the woman missed them. The reasons were not recorded.

3. On 31 May, the woman did not initially collect her methadone, but collected it in the afternoon, and told a nurse that she was still vomiting. The nurse contacted a GP who prescribed anti-sickness medication which she received that evening. The nurse mentioned to the GP that the woman was very thin.

4. On Sunday 1 June, the woman was still vomiting and had diarrhoea. A nurse weighed her and noted that she had lost three stone in almost 11 weeks. The on-call GP asked the nurse to send an urgent blood sample to hospital and to give the woman a rehydration supplement. That evening, officers found the woman on the floor of her cell. She said she had stomach cramps and still had vomiting and diarrhoea. Her clinical observations were normal and a nurse advised prison staff to keep an eye on her.

5. The next morning, 2 June, a doctor saw the woman and arranged for her to go to hospital as a routine admission. That afternoon, the woman collapsed in her cell and went to hospital by emergency ambulance. Two officers accompanied her and used an escort chain to restrain her.

6. Tests in hospital revealed likely Crohn's disease. The woman appeared to improve, but on 6 June, she suddenly deteriorated. Hospital staff could not resuscitate her and pronounced her death at 9.10am.

7. The woman's next of kin, her partner, was a prisoner at HMP Cardiff. He did not learn that the woman was in hospital until 9.30am on 6 June, when a prison chaplain, who had been contacted by Eastwood Park, told him that she was seriously ill. At 10.00am, the chaplain informed him that she had died. Because of a breakdown in communication, the prison's family liaison officer did not visit the woman's partner, until some hours later.

8. The clinical reviewer found that the woman's care was the prison was largely equivalent to that available in the community, but tended to be reactive and that her sudden death could not have been anticipated or avoided. However, although her clinical presentation was unusual, he considered that staff could have been more proactive in questioning underlying causes of her symptoms and significant weight loss. Some aspects of the family liaison were not effective and we are not satisfied that the use of restraints in hospital was fully justified and in line with her risk. We make three recommendations.

## THE INVESTIGATION PROCESS

9. The investigator, issued notices to staff and prisoners at HMP & YOI Eastwood Park informing them of the investigation and asking anyone with relevant information to contact her. Two prisoners responded.

10. The investigator obtained copies of the woman's prison medical records and relevant extracts from her prison records. She interviewed 15 members of staff and two prisoners at the prison and by telephone, during June and July.

11. NHS England commissioned the clinical reviewer to review the woman's clinical care at the prison.

12. We informed HM Coroner for Avon district of the investigation, who provided the post-mortem report. We have sent the Coroner a copy of this investigation report.

13. One of the Ombudsman's family liaison officers and the investigator visited the woman's partner, her nominated next of kin and explained the investigation process. Her partner was concerned about the woman's treatment in prison and about how the prison had informed him of her death. Other family members were also concerned about the woman's treatment and asked whether she had received her methadone in prison. The woman's partner and family also received the draft report. They did not make any further comments.

14. The prison also received the draft report and raised some factual inaccuracies. These have been amended and one outstanding matter dealt with via separate correspondence with the prison.

## HMP & YOI EASTWOOD PARK

15. HMP & YOI Eastwood Park is a closed local prison holding about 360 adult and young adult women on remand and serving short sentences. It has a mother and baby unit. Bristol Community Health (BCH), Hanham Health and Avon and Wiltshire Partnership Trust provide health care. There is no healthcare manager responsible for all aspects of the delivery of healthcare services at Eastwood Park so all recommendations in this report are directed to the Governor.

16. 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.

### HM Inspectorate of Prisons

17. The last inspection of Eastwood Park was 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. The report found that the relationships between staff and prisoners were particularly strong, that healthcare services were good and women received thorough and timely care.

### 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. 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 impacted on prisoner health. The Board praised the work of the Substance Misuse Psychosocial Team.

### Previous deaths at Eastwood Park

19. There have been two deaths from natural causes at Eastwood Park since November 2013. We have raised the issue of the unjustified use of restraints and communication with the ambulance service before.

## KEY EVENTS

20. The woman was remanded to HMP Eastwood Park on 17 March 2014, and on 22 May, received a six months prison sentence for handling stolen goods. She was due to be released from prison on 16 June 2014. (The woman had been eligible for release on home detention curfew on 22 May, the day she was sentenced, but her record notes "insufficient time to assess.")

21. On the evening of 17 March, a healthcare assistant completed the woman's first reception health screen. The woman tested positive for opiates, methadone and benzodiazepine (a tranquilizer, which is sometimes taken illicitly). She told the nurse she had a prescription for 60 milligrams of methadone daily and took mirtazepine (an antidepressant). The healthcare assistant recorded her weight as 69.8 kilograms (11 stone), her height as five feet ten inches and her BMI (body mass index) as 22 (within the healthy range).

22. The same evening, a prison GP saw the woman, who said she used 11 grams of heroin a day. The GP noted the woman displayed mild to moderate signs of withdrawal. The doctor prescribed methadone, metoclopramide (to prevent nausea), paracetamol and peppermint oil (which are standard medications for individuals withdrawing from drugs). The doctor decided to check the prescription of mirtazapine with the woman's community GP.

23. The woman went to Kinnon Unit, the prison's substance misuse unit. Staff did not raise any concerns about her. On 18 March, the nurse carried out a general health assessment which did not identify any concerns apart from high risk factors for blood borne viruses.

24. On 19 March, a nurse assessed the woman further. The woman said she was not experiencing any nausea or sickness, which can be signs of withdrawal from drugs. The GP continued the woman's prescription for methadone, but did not prescribe mirtazapine as her community GP said that she did not take this regularly.

25. On 2 April, the woman moved to a shared cell on a standard residential unit. On 16 April, the woman missed an appointment at the nurses' clinic for a substance misuse review. Staff rescheduled this for 28 April, when a nurse saw the woman and noted she was still on methadone, had completed her in-cell work and had one-to-one support from a member of the Substance Misuse Psychosocial Team. The woman asked why she had not been prescribed mirtazapine. The nurse checked with the mental health team and, as no one had referred the woman to the team, she made a referral that day.

26. On 12 May, a nurse took a blood test to check for blood borne viruses which indicated that the woman had antibodies in her system which could fight hepatitis C. The results of a further blood test were not available until after the woman's death, but showed she had been positive for hepatitis C.

27. On 15 May, the woman told a healthcare assistant that she had a migraine and paracetemol and ibuprofen were not helping. The healthcare assistant arranged for her to see a nurse the same day, who asked a GP to consider prescribing migraleve (a strong pain relief specifically for migraine headaches). The GP wanted to examine the woman before prescribing migraleve and made an appointment for 22 May. On 22 May, the woman did not attend as she was scheduled to attend a court appearance by video. No one rearranged the appointment at the time.

28. On 26 May, an officer noted that another prisoner had told her that she was concerned about the woman, as she was rarely coming out of her cell and was not eating. The officer recorded that she had spoken to the woman, who was difficult to engage with, but had told her that she had been eating. The officer noted that staff should keep an eye on the woman, and passed the concerns on to a nurse.

29. The nurse went to see the woman in her cell that day. She noted that the woman had been talking to another prisoner at the time, looked well and had communicated normally. The woman told the nurse that she was worried she had lost a lot of weight, even though she was eating normally, and that she had stomach cramps. The nurse noted that the woman looked very thin, although her BMI had been normal in March when she had arrived at the prison. She did not weigh the woman, but made an appointment for her to see a nurse for weight monitoring on 28 May. She also made an appointment for the woman to see a GP about her migraines on 28 May, as the planned review on 22 May had not taken place.

30. On 26 and 27 May, officers recorded that they were continuing to monitor the woman and offer her support. The duty governor instructed staff to continue to keep an eye on the woman. On 28 May, the woman did not attend her healthcare appointments for that day. Staff rescheduled them for 2 June.

31. At 4.05am on 29 May, an officer asked a nurse to examine the woman who was vomiting and had diarrhoea. The nurse advised her to drink plenty of fluids and to rest. He recorded that her temperature was 37 degrees, oxygen saturation levels were 98%, pulse 85, blood pressure of 107/71 and her respiratory rate was 12 breaths per minute. All these observations were within the normal range.

32. The nurse noted that the woman's cellmate also had diarrhoea. He advised officers that, until they were clear of diarrhoea for 48 hours, to minimise the risk of infection, the woman and her cellmate should stay in their cells and leave only for necessary tasks, when the other prisoners were locked up. The nurse told us that he had been unable to check the woman's medical record on 29 May, for information about her history, because the computer system was not working.

33. The nurse asked wing officers to check the woman and her cellmate regularly. The wing observation book shows that officers observed the woman for the rest of the day, but there is nothing recorded for 30 May in the observation book or the woman's personal record.

34. At 1.45pm on 29 May, a nurse saw the woman in her cell and noted that she had sickness and diarrhoea and that she should remain as 'rest in cell'.

35. At approximately 5.45am on Saturday 31 May, the woman rang her cell bell and told an officer that she felt as if she was nearly passing out. A nurse came to see the woman straight away. She recorded that she found it difficult to assess the woman as she would not look at her or speak much. Her cellmate told the nurse that the woman had been feeling faint, kept vomiting and had stomach pains. The nurse took the woman's temperature which was still 37 degrees. Her pulse rate was 82, her blood pressure had dropped slightly to 93/88 and her oxygen saturation was down slightly to 96%. The nurse did not consider the observations significant. The nurse told us that she had been concerned that the woman's cellmate had been answering for her. She said that she had decided to ask day staff to assess the woman when she was on her own, but there is no record of this.

36. The woman missed collecting her methadone that morning, but collected it in the afternoon. She told the nurse that she had been unwell and the nurse went back to her cell with her to take her blood pressure which was normal. The woman said she was still vomiting and was worried that she would bring her methadone back up. A nurse told her to drink plenty of fluids and said she would contact a GP for anti-sickness medication. The nurse told the GP that the woman was very thin and vomiting. A doctor prescribed 21 metclopramide (anti-sickness medication) to take three times a day, but did not see the woman.

37. At 5.45pm, a wing officer told a nurse, who was administering medication, that the woman had rung her cell bell and asked when a nurse would be coming to see her. The nurse said nurses had already seen the woman twice that day. The woman then went to the wing medication hatch and the nurse gave her anti-sickness medication and encouraged her to attend regularly to get it.

38. At 3.58pm on Sunday 1 June, officers asked the nurse to see the woman in her cell. The woman showed a nurse a bowl with vomit in it and told her she had been unwell with sickness and diarrhoea for several days. The nurse thought that the woman looked particularly thin and decided to do a full assessment, including weighing her using portable scales. The woman's weight was 50.6kg (eight stone) and her BMI was 15.97, signifying that she was underweight. She had lost three stones since she had arrived at the prison in March. She was able to walk in a straight line and complete her sentences and did not report any pain. A nurse was concerned about her and contacted the on-call GP. He asked that an urgent blood sample should be sent to hospital and that healthcare staff should give the woman dioralyte (a rehydration supplement). The nurse took a blood sample and sent it off. At 8.21pm, the nurse gave the woman some dioralyte and advised her to sip it gradually. There is no evidence that any healthcare staff followed up the results of the blood test.

39. At approximately 10.45pm, at the request of wing staff, the nurse went to see the woman who was on the cell floor. She told the nurse that she was still experiencing vomiting, diarrhoea and abdominal pain. The nurse checked her clinical observations which were all in the normal range. He noted that

she seemed very weak and dehydrated and had not drunk her dioralyte. He helped her back into bed and told her it was important to drink and replace lost fluids. The nurse asked prison staff to keep an eye on her throughout the night. He told us that he asked for a doctor to see her the next morning.

40. An entry in the wing observation book, at 8.15am on 2 June, noted that handover instructions for day staff coming on duty, included the need to monitor the woman and liaise with the duty nurse.

41. On 2 June, the officer told the nurse at the medication hatch that the woman was too ill to come and get her methadone and other medication. This was unusual, as records show that she had never missed a dose of methadone. The nurse checked the prescription and ensured the woman's received her anti-sickness medication and dioralyte.

42. The woman went to the medication hatch at the end of the morning to collect her methadone. The nurse told us that looked poorly. She gave the woman her methadone and a nurse asked a doctor to come to the wing to see her.

43. At 10.13am, a doctor examined the woman and noted that she had lost a significant amount of weight, was constantly vomiting, despite anti-sickness medication, and was suffering from diarrhoea and general weakness. The doctor decided to send the woman to hospital as a non-urgent patient for further investigation.

44. The control room log shows that an operational support grade, made a non-urgent request for an ambulance at 10.58am and noted that he expected it to arrive within two hours. The operator gave the OSG an incident number and told him to call 999, if the woman got worse.

45. At approximately 12.10pm, an officer went to the woman's cell and her cellmate told her that the woman had been sick. An officer also came to the cell and said she would get a nurse. The officer left the cell for a few moments and when she returned she found the woman lying on the floor. Her cellmate had moved her onto her side. The officer said the woman was disorientated and she called the healthcare first responder immediately.

46. A nurse came to the cell and the woman told her that she was too weak and cold to get off the floor. The nurse said that she held the woman's hand and chatted to her. The designated healthcare first responder, arrived at about 12.25pm, at which point the woman began to shake and temporarily lost consciousness**.**

47. The nurse immediately radioed for the ambulance request to be up-graded to an emergency and for a doctor to attend**.** The doctor came and noted that, although the woman could talk, she did not seem as alert as when he had seen her earlier that morning.

48. An operational support grade was working in the gate lodge when a nurse requested the ambulance upgrade. Prison records show the nurse requested an emergency ambulance at 12.25pm. The call between the ambulance operator and the nurse then lasted for just over six minutes.

49. An ambulance arrived at 12.51pm and took the woman to Southmead Hospital, Bristol. Two officers escorted her and restrained her with an escort chain (a long chain with a handcuff at each end, one attached to the prisoner and the other to an officer).

50. The hospital admitted the woman and hospital staff attempted to rehydrate her and gave her pain relieving medication. A gastroenterologist examined her. The results of the blood tests, which had been sent to the hospital the day before, showed that the woman's kidney results were normal but her electrolyte and sodium levels were low. After further tests and scans over the next two days, a consultant told the woman that the diagnosis was likely to be Crohn's disease. A surgeon said she did not require surgery and her symptoms could be resolved medically.

51. On 6 June, the woman walked to the bathroom herself and at 7.00am a member of hospital staff recorded that her vital signs were stable and she appeared to have improved. At 7.40am, the woman became agitated and sweaty and asked for pain relief. When the nurse brought medication, the woman was having difficulty breathing. The nurse gave her oxygen and called for emergency assistance. At this point, the nurse asked the prison officers to remove the escort chain, which they did. Hospital staff were unable to resuscitate her and declared her dead. Escort records show this was at 9.10am.

**Family Liaison**

52. When the escort officers removed the restraints to allow hospital staff to attempt resuscitation, they left the room. An officer telephoned a custodial manager to inform her that hospital staff had asked the prison to contact the woman's family. The woman's partner, her nominated next of kin, was a serving prisoner at HMP Cardiff.

53. The records are not clear about the times, but that morning, the chaplain at Eastwood Park spoke to the chaplain at HMP Cardiff who first informed the woman's partner that she was very ill and then at about 10.00am, that she had died.

54. The prison planned that a family liaison officer from Eastwood Park would visit the woman's partner at Cardiff. However, due to a miscommunication, the family liaison officer went to the hospital and waited there as she believed that the woman's partner was going to the hospital. Once the prison realised the mistake, she went to HMP Cardiff to meet him, but this delay meant she did not arrive until late afternoon.

55. The woman's funeral was on 27 June. In line with Prison Service instructions, Eastwood Park offered a contribution towards the cost.

**Support for prisoners and staff**

56. A Governor's notice informed staff and prisoners of the woman's death. A manager debriefed the staff involved, that day and offered them the support of the prison's care team. A supervising officer told the woman's cellmate in person that she had died and arranged appropriate support.

**Post-mortem**

57. A post-mortem report gave the woman's cause of death as 1a) Intestinal perforation and 1b) Crohn's disease.

## ISSUES

### Clinical care

58. The clinical reviewer considered that the woman's care at Eastwood Park was largely equivalent to that she would have received in the community. He did not consider that there was anything Eastwood Park could have done to prevent the woman's death which was due to a sudden perforation of the bowel when she was in hospital. The clinical reviewer said this was a rare complication of her condition with unusually severe consequences. However, he found that much of her care at the prison was reactive with too little investigation of prolonged symptoms. He noted that much of the assessment, triage and review was by relatively junior nurses.

59. The woman first complained of migraines (which can be a symptom of Crohn's disease) on 15 May 2014. She first complained of sickness, diarrhoea and weight loss on 26 May. The clinical reviewer noted that diarrhoea and vomiting are common conditions in prison and the first priority was to prevent this being passed to other prisoners. He was satisfied that these symptoms were initially appropriately managed with an emphasis on infection control. However, when the symptoms became more prolonged there was little consideration given to other medical conditions.

60. On 26 May, the nurse had noted that the woman looked very thin and made appointments for 28 May, for her to have her weight monitored and to discuss her migraines with the doctor. Unfortunately, the woman did not attend these appointments. Staff did not record the reason, but rescheduled them for 2 June. We noted that the woman was still vomiting and had diarrhoea on 29 May and it is possible that she had been too ill to attend her appointments the day before.

61. On 31 May, a nurse said she was unable to assess the woman properly as her cellmate kept intervening. She said that she had asked the late shift, at handover, to assess the woman on her own, but there is no record of this. Later that day, the nurse noted that the woman was very thin, but did not weigh her. She asked the doctor to prescribe anti-sickness tablets which the doctor prescribed but did not see the woman.

62. It was not until 1 June, that the nurse recognised the extent of the woman's weight loss when she weighed her in her cell. At this point, a doctor requested urgent blood tests. Until this date, no one had begun to investigate fully the reasons for the woman's continuing vomiting and diarrhoea.

63. The clinical reviewer noted that the urgent blood tests were sent to the hospital on Sunday evening and the results had not been received by the time the woman was taken to hospital the next day. He says the person who requested the blood tests, or a nominated member of staff, should have actively followed up the urgent blood tests, although earlier results would not have changed the outcome for the woman. Although the woman died of a rare complication of a rare condition, which the clinical reviewer considers

could not have been avoided, we are concerned that there was too little proactive investigation of the woman's symptoms at an earlier stage. We make the following recommendation:

**The Governor should ensure that prisoners reporting symptoms such as significant weight loss and sickness have their symptoms promptly examined and investigated to determine the root cause, with follow up actions carried out by named staff.**

## The Emergency Response

64. There was a protracted telephone call on 2 June, to upgrade the ambulance to an emergency as the ambulance service operator asked many detailed questions. The prison did not give the reference number for the previous call, which we understand would have avoided this delay. However, the member of staff who requested it made it clear that there had been an earlier call and the operator did not ask for the reference. We have previously recommended that there should be a protocol between the prison and South West Ambulance Service Trust to ensure an understanding of the prison context and better communication about the level of priority. The delay did not affect the outcome for the woman, but in other circumstances it could be crucial. We understand that a protocol has been agreed and all staff briefed, so do not repeat our previous recommendation.

## Restraints and escorts

65. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as 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 indicated that medical opinion about he prisoner's ability to escape must be considered as part of the assessment process.

66. On the morning of 2 June, the prison had prepared a risk assessment for The woman to go to hospital. This had authorised the use of handcuffs and a two officer escort, but the medical assessment was completed by an administrator and not a clinician as the court judgement requires. A security collator completed the security assessment and noted that the woman had one disciplinary offence for refusing to attend court. (The woman said that her solicitor had advised her that she did not need to attend.) On no other evidence, the security collator assessed the woman as at medium risk of escape, hostage taking, and of receiving outside assistance. At the same time, she noted that the woman had no other risk factors including that she had no history of absconding or escapes, had not been violent to hospital staff in the past, there was no risk to victims and no relevant previous convictions or police warnings.

67. The woman condition significantly deteriorated a short time later, when she had a seizure and lost consciousness for a while. This led to the prison calling an emergency ambulance. At this point a custodial manager, decided that the woman should be restrained by an escort chain and escorted by two officers.

68. After the woman's was admitted to hospital, the prison completed a further risk assessment on 3 June. A nurse noted that the nature of the medical condition would not prevent her escape. A Security Collator completed the security risk assessment and did not recommend any changes to the level of restraint. A senior manager authorised the continued use of an escort chain and two escorts.

69. Records show checks were carried out every day by a manager and the woman's risk was reviewed. At 4.55pm on 5 June, the last management check before the woman died, a custodial manager authorised the continued use of an escort chain and two escorts.

70. On the morning of 6 June, the woman's condition suddenly deteriorated and a nurse called the hospital emergency team to help try to resuscitate her. One of the escorting officers, tried to stand out of the way, but was prevented from doing so by the escort chain which was attached to the other escort officer and the woman. A nurse asked the officers to remove the chain and the officer took it off. The officers then left the room while hospital staff attempted to revive the woman.

71. The woman was restrained by an escort chain and escorted by two officers during her four day admission to hospital to the point where she became unresponsive. The staff removed restraints only for investigatory procedures. The escort records show that, for most of the time, the woman was in pain and vomiting, and clearly very ill.

72. The Head of Security and Operations told us that an escort chain was the usual method of restraint for women in hospital. It appears to us that this was a default position, irrespective of risk. We are not satisfied that the security risk assessment which found that the woman was a medium risk of escape and of harm to the public was justified by the facts. The woman was serving a short prison sentence for a non-violent offence and there is no evidence that she had caused any problems in prison. She was due to be released from prison on 16 June just ten days after her death. The staff repeatedly noted that she was 'quiet and polite' in the escort records. The use of an escort chain was undignified for a woman in her condition and not justified by any security concerns. We make the following recommendation:

**The Governor should ensure that risk assessments for hospital escorts fully take into account individual circumstances, including evidenced based security assessments, appropriate input from healthcare staff and are based on the actual risk the prisoner presents at the time.**

**Family Liaison**

73. Eastwood Park did not inform the woman's partner or other family member when she was admitted to hospital as an emergency on 2 June. Prison Service Instruction (PSI) 64/2011 says that a prisoner's family should be informed when a prisoner is taken to hospital with a serious condition. Additionally, Prison Rule 22 requires that when a prisoner becomes seriously ill, the governor should "at once inform the prisoner's spouse or next of kin, and also any person who the prisoner may reasonably have asked should be informed".

74. We consider Eastwood Park should have informed her partner, her nominated next of kin, when the woman was first taken to hospital on 2 June The woman had lost consciousness and been admitted to hospital as an emergency. Although the woman's partner was in prison it would have been helpful for him to have been informed of her illness and it might have allowed other members of the woman's family to visit her before she died.

75. The woman's partner did not become aware that she was in hospital until the morning of 6 June. Shortly afterwards the chaplain told him that she had died. The woman's condition deteriorated so quickly on the morning of 6 June that there was no possibility at that stage of any family members being able to get to her bedside before she died.

76. Although the woman's partner was informed of her death promptly, there was a delay in Eastwood Park's family liaison officer visiting him in prison. This was caused by an unfortunate misunderstanding. We are satisfied that as soon as this was identified, the family liaison officer went to Cardiff to give the woman's partner more information about the circumstances. We make the following recommendation:

**The Governor should ensure that a prisoner's family is notified as soon as possible when a prisoner becomes seriously ill.**

## RECOMMENDATIONS

1. The Governor should ensure that prisoners reporting symptoms such as significant weight loss and sickness have their symptoms properly examined and investigated to determine the root cause, with follow up actions carried out by named staff.

2. The Governor should ensure that risk assessments for hospital escorts fully take into account individual circumstances, including evidence based security assessments, appropriate input from healthcare staff and are based on the actual risk the prisoner presents at the time.

3. The Governor should ensure that a prisoner's family is notified as soon as possible when a prisoner becomes seriously ill.