Prisons & Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Ms Claire Woodward a prisoner at HMP New Hall on 11 June 2016

A report by the Prisons and Probation Ombudsman
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Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

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The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Ms Claire Woodward died on 11 June 2016 from the combined effects of methadone and morphine at HMP New Hall. She was 38 years old. I offer my condolences to Ms Woodward's family and friends.

I am concerned that women at New Hall continue to be at risk from secreted illicit drugs, an issue already identified by HM Inspectorate of Prisons and the Independent Monitoring Board. Ms Woodward's case also illustrates the prison's need to review and improve its approach to emergency response.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

Nigel Newcomen CBE
Prisons and Probation Ombudsman **February 2017**

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Summary

Events

1. On 9 June 2016, Ms Claire Woodward was sentenced to 20 weeks imprisonment for theft and was sent to HMP New Hall.

2. At her initial health screen, Ms Woodward told a health professional that she had used heroin that morning and was prescribed a daily 45mls dose of methadone. The health professional tested Ms Woodward's urine and found that it was positive for benzodiazepine, methadone and opiates, so referred her for a substance misuse assessment and to a prison GP.

3. At 9.57pm on 9 June, Ms Woodward received a 10mls dose of methadone. She received a second 10mls dose of methadone at 8.42am on 10 June.

4. Later that day, a health professional performed a drug screening test on Ms Woodward and found that she showed mild signs of opiate withdrawal. Following this screening, a doctor increased Ms Woodward's methadone prescription to 45mls, to be taken in two doses.

5. Also on 10 June, Ms Woodward apparently told another prisoner that she had brought heroin into the prison with her and that she had taken it in the afternoon.

6. At 6.10pm on 10 June, a health professional gave Ms Woodward a 35mls dose of methadone.

7. Later that evening, Ms Woodward told two prisoners that she was not feeling well but she did not want prison staff to be given this information.

8. At 9.11am on 11 June, an officer unlocked Ms Woodward's cell door and told her that it was time to collect her medication. Ms Woodward did not respond so the officer entered her cell and noticed that her lips were a blue-black colour and her skin was mottled. He immediately called a code blue emergency (which indicates that a prisoner is unconscious or not breathing) on his radio.

9. At 9.15am, a nurse and a health support worker responded to the code blue and arrived at Ms Woodward's cell. They noted that her skin was mottled with signs that rigor mortis had set in. They then started cardiopulmonary resuscitation (CPR). After hearing the code blue, a control room operator asked the officer whether an ambulance was required and he said that it was.

10. At 9.35am, paramedics arrived and took over the resuscitation. They were unsuccessful and declared that Ms Woodward had died at 9.40am.

Findings

11. Ms Woodward told another prisoner that she had brought heroin into the prison. We are satisfied that there was no intelligence or anything to suggest that she had concealed drugs. In the circumstances it was reasonable for prison staff to perform a rub-down search rather than a full search.

12. However, we note that HM Inspectorate of Prisons and the Independent Monitoring Board have recently raised concerns about the supply of illicit substances and the number of women smuggling items into the prison on arrival. As it appears that Ms Woodward smuggled heroin into the prison, we believe that the prison needs to do more to improve the processes to reduce the number of women smuggling secreted items into the prison.

13. We agree with the clinical reviewer that healthcare staff quickly identified Ms Woodward's healthcare needs and prescribed her methadone in line with the maintenance regime she received in the community. Overall, the healthcare that Ms Woodward received was equivalent to that she could have expected to receive in the community.

14. While we understand the commendable wish to attempt resuscitation until death has been formally recognised, we are concerned that healthcare staff attempted to resuscitate Ms Woodward when she was clearly dead.

15. We are also concerned that after the officer called a code blue emergency, the control room operator did not immediately call an ambulance and asked the officer whether an ambulance was needed.

Recommendations

- The Governor should review and improve the processes in place to reduce the smuggling of illicit items into the prison.
- The Governor and Head of Healthcare should ensure that staff are given clear guidance about the circumstances in which resuscitation is inappropriate.
- The Governor should ensure that control room operator call an ambulance immediately a medical emergency code is received.

The Investigation Process

16. The investigator issued notices to staff and prisoners at HMP New Hall informing them of the investigation and asking anyone with relevant information to contact him. Two prisoners responded.

17. The investigator visited New Hall on 5 July. He obtained copies of relevant extracts from Ms Woodward's prison and medical records.

18. NHS England commissioned a clinical reviewer to review Ms Woodward's clinical care at the prison.

19. The investigator interviewed two prisoners on 5 July. The investigator and the clinical reviewer also interviewed three members of staff on 2 August.

20. We informed HM Coroner for County of West Yorkshire of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

21. One of the Ombudsman's family liaison officers contacted Ms Woodward's mother to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She wanted to know how Ms Woodward had accessed the methadone and morphine that had caused her death.

22. The initial report was shared with the Prison Service. The Prison Service did not find any factual inaccuracies.

23. Ms Woodward's mother received a copy of the initial report. She pointed out some factual inaccuracies and/or omissions. This report has been amended accordingly.

Background Information

HMP New Hall

24. HMP New Hall is a local prison, holding around 400 remand and sentenced women and young offenders. Spectrum Community Health CIC provided primary health care services until August 2016 and Nottinghamshire Healthcare NHS Foundation Trust provided mental health services. Spectrum Healthcare and Turning Point provided substance misuse services.

HM Inspectorate of Prisons

25. The most recent inspection of HMP New Hall was in June 2015. Inspectors reported that health services were strong, particularly mental health provision. They found that the support for women with substance misuse issues had improved since the previous inspection, but required further work.

26. The inspectors found that support on arrival and during the early days at the prison was very good. They found that security arrangements were generally proportionate, but delays in responding to some intelligence was a concern, particularly given the obvious challenges faced in managing problems with the use of illicit and diverted prescribed drugs.

Independent Monitoring Board

27. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to February 2016, the IMB reported that prison security remained a problem particularly in relation to drugs. They were concerned at the increased incidents of women coming into prison with drugs secreted about their person, though attempts by the prison and the IMB to obtain a body scanner had been unsuccessful.

Previous deaths at HMP New Hall

28. Ms Woodward was the third person to die at New Hall since January 2016. We have previously made a recommendation about the appropriateness of resuscitation.

Key Events

29. On 9 June 2016, Ms Claire Woodward was sentenced to 20 weeks imprisonment for theft and was sent to HMP New Hall.

30. During an initial health screen on arrival at New Hall, Ms Woodward told a health professional that she used heroin intermittently, and she had used it that morning. Ms Woodward also said that Rotherham Drug and Alcohol Services prescribed her a 45mls dose of methadone. She measured Ms Woodward's blood pressure, pulse rate and respiratory rate, which were all normal. She also tested Ms Woodward's urine and found that it was positive for benzodiazepine, methadone and opiates. She referred Ms Woodward for a substance misuse assessment and to a prison GP.

31. Later that evening, a health professional reviewed Ms Woodward and noted that she looked well. She prescribed Ms Woodward 240mls of methadone, to be taken at different times over the next seven days. She also asked night staff to check her hourly.

32. At 9.57pm, a health professional gave Ms Woodward a 10mls dose of methadone.

33. A health professional checked on Ms Woodward hourly through the night and, from 1.00am, she appeared to be asleep.

34. At 8.42am on 10 June, a health professional gave Ms Woodward a 10mls dose of methadone.

35. Later that day, a health professional performed the first observation of Ms Woodward as part of a drug screening test. She found that she showed mild signs of opiate withdrawal though her blood pressure, pulse rate and respiratory rate remained normal. Following this screening, a prison GP increased Ms Woodward's methadone prescription to 45mls, to be taken in two doses.

36. Also on 10 June, Ms Woodward apparently told another prisoner that she had brought heroin into the prison with her and that she had taken it in the afternoon.

37. At 6.10pm on 10 June, a nurse gave Ms Woodward a 35mls dose of methadone.

38. Later that evening, a prisoner saw Ms Woodward, who said that she was not feeling well and did not want any dinner. After Ms Woodward did not attend dinner, a fellow prisoner went to her cell and Ms Woodward apparently said that she had passed out but that she did not want any prison officers to know this. The prisoner agreed not to pass this information to prison staff, but felt that Ms Woodward clearly looked unwell.

Events of the morning of 11 June

39. At 5.20am on 11 June, an officer performed a visual roll check to ensure that all the prisoners on Ms Woodward's wing were present. She did not have any concerns about Ms Woodward's wellbeing.

40. Approximately, ten minutes later, a prisoner who lived in the cell below Ms Woodward's cell heard her coughing loudly. This information was not given to a member of staff until after Ms Woodward's death.

41. An hour later, at 6.30am, an officer performed a second visual roll check but did not have any concerns about Ms Woodward's wellbeing.

42. At around 9.00am, an officer started unlocking cells on Ms Woodward's wing so that the prisoners could obtain their medication. At approximately 9.11am, he unlocked Ms Woodward's cell door and told her that it was time to collect her medication. Ms Woodward did not respond so he entered her cell. He noticed that her eyes were shut and her leg was outside the duvet and was discoloured. He pulled the duvet off Ms Woodward and noticed that her lips were a blue-black colour and her skin was mottled. He immediately called a code blue emergency (which indicates that a prisoner is unconscious or not breathing) on his radio.

43. After calling the code blue, the control room operator asked the officer whether an ambulance was required and he said that it was.

44. At approximately 9.15am, a nurse and a health support worker responded to the code blue and went to Ms Woodward's cell. The health support worker collected the emergency bag. On arrival, they found that Ms Woodward was unresponsive, not breathing and cold to the touch. They also noted that her skin was mottled with signs of rigor mortis. Neither noted any signs of drugs use.

45. The nurse and an officer started cardiopulmonary resuscitation (CPR), while the health support worker attached a defibrillator and inserted an oral pharyngeal airway. Other nurses arrived and helped with CPR. The CPR continued while the health support worker gave her oxygen. The defibrillator advised that no shock was required. At approximately 9.35am, paramedics arrived and took over the resuscitation. They were unsuccessful and declared that Ms Woodward had died at 9.40am.

Contact with Ms Woodward's family

46. Following Ms Woodward's death, the prison appointed two officers as family liaison officers. At 3.23pm on 11 June, they arrived at the home address of Ms Woodward's mother to break the news of her death and to offer their condolences and support.

47. On 14 June, a Governing Governor wrote to Ms Woodward's mother to offer her condolences and ongoing support from her staff. One officer continued to support Ms Woodward's mother until her funeral.

48. Ms Woodward's funeral was held on 1 July and the prison contributed to the costs of the funeral, in line with national instructions.

Support for prisoners and staff

49. After Ms Woodward's death, a senior prison manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

50. The prison posted notices informing other prisoners of Ms Woodward's death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Ms Woodward's death.

Post-mortem report

51. The post-mortem report confirmed that the combined effects of methadone and morphine caused Ms Woodward's death, as both drugs have a sedative effect and can depress the central nervous and respiratory systems. The concentration of morphine was consistent with the use of a compound, such as heroin, that metabolises to morphine.

Findings

Searching strategy

52. Prison Service Instruction (PSI) 07/2016 'Searching of the Person' confirms that, on reception to prison, all female prisoners must be given a rub-down search (the lowest category of searches), which is not designed to be an intimate search. The PSI also confirms that officers must not perform full searches on female prisoners as a matter of routine but only when intelligence or reasonable suspicion suggests that an item is being concealed on the person. New Hall has a local Searching Strategy that supports PSI 07/2016.

53. When Ms Woodward arrived at New Hall, there was no intelligence or reasonable suspicion that she had concealed drugs on her person and it was only following her death that a prisoner told the investigator that Ms Woodward had brought heroin into the prison. While a full search may have found the heroin that Ms Woodward had smuggled into the prison, and which appears to have caused her death, we are satisfied that without any intelligence or reasonable suspicion that she had concealed drugs, it was appropriate for prison staff to only perform a rub-down search rather than a full search.

54. PSI 09/2016 'Cell, Area and Vehicle Searching' confirms that all prisons must carry out intelligence-led cell searches. However, as with her arrival, there was no intelligence that Ms Woodward was in possession of heroin on 10 June and we are satisfied that it was appropriate that the prison did not perform a search of Ms Woodward's cell.

55. While we recognise that there was no intelligence to suggest that Ms Woodward had smuggled drugs into the prison, both HM Inspectorate of Prisons and the Independent Monitoring Board had concerns about the supply of illicit substances and the increased incidents of women secreting items on arrival into the prison. As these concerns have been present since at least June 2015, and have not been resolved a year later, we believe that the prison need to review their security procedures and introduce further measures to reduce the smuggling of secreted items. The presence of a Body Orifice Security Scanner chair and hand held metal detectors are insufficient to detect secreted drugs and we believe that the prison needs to do more. We make the following recommendation:

    The Governor should review and improve processes in place to reduce the smuggling of illicit items into the prison.

Clinical care

56. We agree with the clinical reviewer that, following her arrival at New Hall, healthcare staff quickly identified Ms Woodward's healthcare needs and prescribed her methadone in line with the maintenance regime she received in the community.

57. On the evening of 10 June, Ms Woodward told two prisoners that she was feeling unwell but no one told prison or healthcare staff that she was unwell. Without any information to the contrary, we are satisfied that healthcare staff did not need to pay additional attention to Ms Woodward's wellbeing. Overall, the healthcare

that Ms Woodward received was equivalent to that she could have expected to receive in the community.

Resuscitation attempt

58. At the time of Ms Woodward's death, Spectrum Community Health CIC provided primary healthcare services at the prison. Their Resuscitation Policy, issued in March 2016, states that cardiopulmonary resuscitation will be attempted for all prisoners unless there is a clear indication that it should not be performed. The policy states that one of these indications is when there is clear evidence that rigor mortis has set in, which is described as "stiffness and rigidity of the body, limbs held in a fixed and rigid position".

59. Additionally, the National Offender Management Service provided guidance on when not to perform cardiopulmonary resuscitation, also issued in March 2016, which states that resuscitation would be futile when the patient shows signs of blood pooling or rigor mortis.

60. While examining Ms Woodward, both the nurse and health support worker noticed that there was blood pooling and rigor mortis. During interviews, the nurse explained that while rigor mortis was present in Ms Woodward's arms, she could still move them, while the health support worker said that there were only small signs of rigor mortis and she could not sure for how long Ms Woodward had been unresponsive. The nurse also confirmed that she had not received any training on Recognition of Life Extinct (ROLE). Based on this information, they agreed that it was appropriate to attempt resuscitation.

61. The clinical reviewer confirmed that the ingestion of certain drugs may cause abnormal rigidity and that it was her opinion that, due to the nurse's lack of training in ROLE, she had sought to act in Ms Woodward's best interest by attempting resuscitation.

62. While we note the clinical reviewer's opinion and we understand the commendable wish to attempt resuscitation until death has been formally recognised, staff should understand that they are not required to carry out cardiopulmonary resuscitation in these circumstances. Trying to resuscitate someone who is clearly dead is distressing for staff and undignified for the deceased. We make the following recommendation:

    The Governor and Head of Healthcare should ensure that staff are given clear guidance about the circumstances in which resuscitation is inappropriate.

Roll checks

63. When the nurse and health support worker examined Ms Woodward on the morning of 11 June, they both noted that she showed some signs of rigor mortis. Rigor mortis does not usually begin until about two hours after death and in normal circumstances is complete within three to six hours.

64. In the early hours of 11 June, two officers checked that Ms Woodward was present in her cell, but neither of the officers had any concerns about her wellbeing, despite the possibility that she had been dead for some time.

65. PSI 24/2011 ‘Management and Security of Nights’ states that night staff must receive a briefing on any prisoner who requires a higher level of observation than normal, which includes those at risk of suicide or self-harm, those at risk of escape or those with medical issues. Ms Woodward did not fall into any of these categories so we believe that it was appropriate that neither officer checked on her wellbeing more closely.

Emergency response

66. When an officer found Ms Woodward unresponsive, he immediately called a code blue emergency, which led to a quick response from healthcare staff. However, while he called the code blue at approximately 9.11am, the control room operator did not call an ambulance until 9.15am after asking the officer whether an ambulance was needed.

67. PSI 03/2013 ‘Medical Emergency Response Codes’, contains a mandatory instruction that following the issue of a code blue, staff must understand they should not delay summoning emergency assistance and it is not be a requirement for a member of staff to confirm that an ambulance is required. The prison also issued a Notice to Staff, on 30 March 2016, which reiterated that a control room operator must immediately call an ambulance when a code blue is called and not delay the call waiting on further details.

68. By asking the officer whether an ambulance was required, the control room operator caused an unnecessary delay. While the delay would not have altered the outcome for Ms Woodward, in other emergencies any delay could be critical. We make the following recommendation:

    The Governor should ensure that control room operator call an ambulance immediately a medical emergency code is received.

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