Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Ms Michaela Sweeting a prisoner at HMP Eastwood Park on 2 June 2016

A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE

PO Box 70769
London, SE1P 4XY
Email: mail@ppo.gsi.gov.uk
Web: www.ppo.gov.uk
T | 020 7633 4100
F | 020 7633 4141

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*

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.

On the morning of 2 June 2016, staff found Ms Sweeting unresponsive in her cell. At 7.42am, a doctor pronounced Ms Sweeting dead. She was 38 years old. I offer my condolences to Ms Sweeting's family and friends.

Ms Sweeting had only been in custody at Eastwood Park since 28 May and this was her first time in custody. When she arrived at Eastwood Park, staff identified that she required both alcohol and drug detoxification. Due to the serious nature of the charge she was facing, she was placed on suicide and self-harm monitoring procedures.

I am concerned at the deficiencies in the management and delivery of suicide and self-harm procedures and in the emergency response. The clinical review identified weaknesses in healthcare delivery, and has concluded that these meant that the care Ms Sweeting received was not equivalent to that she could have expected in the community.

The Coroner recorded the cause of Ms Sweeting's death as 'unascertained'. However, had all prison and nursing staff carried out their checks properly, any medical issues Ms Sweeting may have had might have been identified and addressed. We cannot know whether this would have led to a different outcome but it is clear that the actions of some staff were seriously remiss and lessons need to be learned. I would expect the outcome of the review of Kinnon Unit to assist in this process and the Deputy Director for the Women's Estate needs to assure himself that any implications for safety at Eastwood Park have been fully addressed.

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**

Contents

Summary 1
The Investigation Process 3
Background Information 4
Key Events 6
Findings 12

Summary

Events

1. Ms Michaela Sweeting arrived at HMP Eastwood Park on 28 May 2016. Ms Sweeting had a history of illicit drug use, and during a reception health screen tested positive for methadone, opiates and benzodiazepines. The healthscreen also recorded a history of mental health issues, including self-harm. Ms Sweeting told nursing staff that she suffered from bi-polar disorder and had a personality disorder. Due to her mental health history, previous self-harm and the serious charge she was facing, staff opened an ACCT document, meaning that Ms Sweeting would be observed and supported under the Prison Service suicide and self-harm monitoring process.

2. A mental health assessment was also completed when Ms Sweeting arrived at Eastwood Park. It did not highlight any mental health problems other than those related to substance misuse. Following the reception process treatment for opiate and alcohol withdrawal started and Ms Sweeting was given a cell on Kinnon Unit, which is the prison's detoxification wing.

3. Under ACCT procedures, staff conducted observations on Ms Sweeting at least three times each hour.

4. On 1 June, at 10.22pm, a nurse saw Ms Sweeting, as she was feeling unwell. She had been vomiting and complained of a stomach ache. He checked Ms Sweeting's temperature, pulse and oxygen levels, all of which were normal, and concluded that her symptoms were probably due to something she had eaten.

5. During the remainder of the night, staff continued to check on Ms Sweeting and said that on each occasion she could be heard snoring, and no concerns were raised. On 2 June, at 7.00am, staff discovered Ms Sweeting unresponsive in her cell. Nursing staff were alerted and entered the cell, immediately starting cardiopulmonary resuscitation (CPR) and contacting the emergency services. Efforts to resuscitate Ms Sweeting were continued by both nursing staff and paramedics, but Ms Sweeting was pronounced dead at 07.42am.

Findings

6. Reception staff at Eastwood Park appropriately considered the information recorded about Ms Sweeting and placed her on ACCT monitoring procedures.

7. There was no healthcare input at the initial ACCT case review, although this is a mandatory requirement for all first case reviews. Ms Sweeting's caremap was completed and it detailed the immediate concerns relating to her and how these would be addressed.

8. Ms Sweeting was to be observed as part of the ACCT procedures at least three times each hour. Over 1 and 2 June, staff recorded 22 checks on Ms Sweeting conducted between 12.00pm and 7.20am. However, not all of the observations recorded could be considered appropriate and CCTV confirms that some did not take place at all.

9. We are satisfied that nursing staff acted swiftly and appropriately when Ms Sweeting was discovered on 2 June, and emergency services were requested in line with national policy.

10. The nurse claimed that he had 'informally' checked on Ms Sweeting several times during the night and recorded in the medical notes that he had last seen her at 5.30am, when Ms Sweeting was asleep and snoring. CCTV shows that this is not the case and his account is incorrect. The clinical reviewer concludes that with respect to clinical note making, the care of Ms Sweeting was far below that which she would have received in the community.

11. The Coroner was unable to establish any definitive reason for Ms Sweeting's death and has recorded the cause as 'unascertained'. Given the doubts expressed by the clinical reviewer over the quality of her care and given the inconsistencies and deficits in the quality performance of ACCT observations, then it is possible that an earlier intervention might have led to a different outcome for Ms Sweeting. We would expect the review of Kinnon Unit commissioned by the Governor to consider whether broader issues exist and if so what action may be required.

Recommendations

The Governor should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidance, including:

- A multidisciplinary approach for all case reviews with continuity of case management and healthcare staff attending first case reviews.
- Completing observations as directed by the ACCT document with the aim of satisfying themselves of the prisoners's well-being.

In respect of clinical note taking:

- The Director of Nursing for the healthcare provider should provide assurance to the commissioners that this process is robust and working.

The Investigation Process

12. The investigator issued notices to staff and prisoners at HMP Eastwood Park informing them of the investigation and asking anyone with relevant information to contact him. Two prisoners asked to speak to Mr Williamson and he returned to the prison on 15 June, and completed interviews with the two women, as they were due to be released.

13. The investigator obtained copies of relevant extracts from Ms Sweeting's prison and medical records.

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

15. The investigator interviewed nine members of staff at Eastwood Park. He and the clinical reviewer interviewed several of the healthcare staff together. The investigator also obtained police witness statements made by staff.

16. We informed HM Coroner for Avon of the investigation, and he gave us the results of the post-mortem and toxicology examinations. We have sent the coroner a copy of this report.

17. One of our family liaison officers contacted Ms Sweeting's mother to explain the investigation. The family had the following questions:

    1. They asked for details of all medication that Ms Sweeting had been given upon arrival at prison;

    2. As Ms Sweeting might have been suffering from alcohol and drug withdrawal, they asked whether she had been given any withdrawal medication and whether she had been referred for any substance misuse assessments;

    3. They asked for details of the induction process, enquired how Ms Sweeting's state of mind was judged and whether her mental health was assessed;

    4. They asked for as much information as possible about what happened to Ms Sweeting between lockdown on Wednesday evening until unlock on Thursday morning. They asked whether CCTV was available and whether it showed anybody entering Ms Sweeting's cell during the 24 hours prior to her death.

    5. They asked who was the last person Ms Sweeting had spoken to prior to her death.

18. Ms Sweeting's family received a copy of the draft report, but no comments have been received regards the content of the report.

Background Information

HMP Eastwood Park

19. HMP Eastwood Park in South Gloucestershire opened as a female prison in March 1996, taking in prisoners from HMP Pucklechurch. The Kinnon unit, a substance misuse unit, opened in 2009. Bristol Community Health and Avon and Wiltshire Partnership Trust provide primary care, mental health care and substance misuse services.

20. 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

21. Although an inspection has recently taken place, the report has not yet been published. The most recent report was published in April 2014. This comments that first night and early days support was now very good and much improved since the previous inspection. Most women felt safe, although one out of three had felt unsafe at some time. Nevertheless, safer custody work had developed and this was reflected in the experience of most women at the prison. There had been no self-inflicted deaths for some years and support for women who were vulnerable to self-harm was good. Incidences of self-harm had greatly reduced since the last inspection, although they were still high, and a small number of individual women accounted for a significant proportion of this figure. The complex needs unit provided some excellent support to the women with the highest level of need. Significant progress had been made in providing treatment and support for the high number of women with substance misuse problems.

Independent Monitoring Board

22. Each prison in England and Wales has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help ensure that prisoners are treated fairly and decently. In its most recent annual report for the year to October 2015, the IMB comments that mental health services have seen very positive developments with the addition of new staff and a dedicated wing for those with a personality disorder. Physical health issues, including substance misuse, raise the most applications to the IMB, with access to timely healthcare and continuity of medication being the most frequently cited. At the time of issuing their report, the IMB also commented that Eastwood Park had around 40 prisoners on special measures to prevent self-harm at any one time. It noted that board members had witnessed many incidences of staff dealing with distressing and challenging situations with care and compassion. However, the IMB also comments that there had been a worrying increase in the number of incidents of self-harm.

Previous deaths at HMP Eastwood Park

23. Ms Sweeting's death was the first potentially natural causes death at Eastwood Park since 2014. However, there have recently been three self-inflicted deaths there.

Assessment, Care in Custody and Teamwork

24. ACCT is the care planning system the Prison Service uses to support prisoners at risk of suicide or self-harm. The purpose of the ACCT is to try to determine the level of risk posed, the steps that staff might take to reduce this and the extent to which staff need to monitor and supervise the prisoner. Checks should be made at irregular intervals to prevent the prisoner anticipating when they will occur. Part of the ACCT process involves assessing immediate needs and drawing up a caremap to identify the prisoner's most urgent issues and how staff will address these. Staff should hold regular multidisciplinary reviews and should not close the ACCT plan until all the actions of the caremap are completed. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011, *Management of prisoners at risk of harm to self, to others, and from others*.

Key Events

25. On 28 May 2016, the Crown Court remanded Ms Michaela Sweeting into the custody of HMP Eastwood Park. She was charged with unlawful killing. This was the first time Ms Sweeting had been imprisoned. While at court, a person escort record (PER) form was completed recording that Ms Sweeting suffered from borderline personality disorder. The PER form also indicated that Ms Sweeting had previously tied clothing around her neck, had taken an overdose, used plastic clips and pens to self-harm, had been violent towards the police, was alcohol dependant and had expressed an intention to take her own life in custody.

26. A custody officer completed a suicide and self-harm warning form. She recorded that Ms Sweeting was very upset due to the charges she faced, and that she had previously self-harmed.

27. On Ms Sweeting's arrival at Eastwood Park, escort staff passed all documentation to the reception officer. In view of the comments made by Ms Sweeting and information provided, the officer opened an ACCT (Assessment, Care, Custody and Teamwork) document. She recorded the reasons for opening the ACCT as: Ms Sweeting's charge of manslaughter, a history of self-harm by cutting and the scratches she had made to her arm while in police custody. She also recorded that Ms Sweeting said she was "going to do her best" not to self-harm, but was nervous about being in prison. She recorded that staff should observe Ms Sweeting at least three times each hour.

28. A healthcare assistant completed Ms Sweeting's initial healthscreen, which included a urine test. Ms Sweeting tested positive for buprenorphine, benzodiazepam, methadone and opiates. An alcohol screening was also completed. Ms Sweeting denied any current thoughts of self-harm but said that she had a psychiatric history and had been diagnosed as bipolar, with a personality disorder. She said that she was currently being prescribed 20mg diazepam daily. He recorded a history of daily methadone and heroin misuse and weekly benzodiazepam misuse. Ms Sweeting told him that she had taken a drug overdose in March 2016, and was alcohol dependant. He made referrals for Ms Sweeting to be seen by the GP and substance misuse team.

29. A mental health nurse was asked to see Ms Sweeting in reception. She recorded that Ms Sweeting presented as very hostile and said that she did not want to speak to the mental health team, because she "could not be bothered". She reassured Ms Sweeting that she would not spend long with her and someone would see her during the week for a more in depth assessment. Ms Sweeting indicated that she was happy with this. She recorded that although initially hostile Ms Sweeting had engaged and was able to answer questions. Ms Sweeting said that she had spent four days in police cells and been unable to have a cigarette. She told her that she was under the supervision of the mental health team in the community and was being prescribed medication, mood stabilisers and benzodiazepine but was unsure which specific medications. Ms Sweeting said that she had not engaged in the community, as "she could not be bothered and saw no point". Ms Sweeting told her that she had been diagnosed

as bipolar and with a personality disorder, had two dependant children aged 13 and 9, and was concerned about losing her flat.

30. The mental health nurse recorded that Ms Sweeting was clean and tidy in appearance, and that the mental health team would assess her more completely once she was permanently resident in her own cell and had had time to absorb the severity of her situation.

31. A prison GP then saw Ms Sweeting. Ms Sweeting told her that she had been using subutex and methadone in the community. She said that she was keen to go back onto methadone as this had suited her better than subutex in the past. She recorded that Ms Sweeting showed no obvious signs of alcohol dependence on reception. She agreed that Ms Sweeting would be prescribed 10mg chlordiazepoxide (librium,) thiamine and vitamin B, all used to treat alcohol withdrawal. She also prescribed a 1mg oral solution of methadone at reception, and agreed that this would be gradually raised, to 40mg as part of a detoxification regime. She planned to review this prescription five days later.

32. Nursing staff at HMP Eastwood Park monitor all prisoners identified on reception as requiring detoxification for the first three days. This is to identify any escalation in withdrawal symptoms and ensure that any medication is proving effective.

33. On 29 May, a Supervising Officer (SO) completed an ACCT assessment with Ms Sweeting. Ms Sweeting said that she was sorry for bringing shame on her family. She told him she had spoken with her family on the phone, and her parents were looking after her children. When asked about recent incidences of self-harm, Ms Sweeting said she had taken her solicitor's pen while in police custody and made scratches to her arms. She told him that she self-harmed to relieve stress and enjoyed the feeling of release. Ms Sweeting said she had self-harmed for many years and did not expect to die as a result.

34. Ms Sweeting said she was upset at letting her family down and was concerned about the impact her imprisonment would have on her children. She said she had previously been sectioned under the Mental Health Act, and had spent time in psychiatric hospitals since the age of 16. When asked about current thoughts of suicide or self-harm, Ms Sweeting said that she did not want to die, but could not think about anything, other than why she was in custody. She told the SO that she had no plans to self-harm.

35. Ms Sweeting said that in the community she had the support of her family, and coped by using drink and drugs to block out the negative feelings. She said that she felt better having had the chance to speak to her father that morning.

36. Following the assessment, a SO chaired an ACCT review attended by the first SO and Ms Sweeting. He recorded that due to the nature of her charges, and with no previous knowledge of Ms Sweeting, the observations would remain at three per hour. He completed the caremap, detailing the immediate issues to be addressed, including the need for a full induction, an appointment with the housing advisor, and a referral to the mental health team.

37. Following reception procedures, staff moved Ms Sweeting to Kinnon Unit, the detoxification unit at Eastwood Park. Two fellow prisoners befriended her when she arrived. The two women contacted the investigator to share their knowledge of Ms Sweeting.

38. Both women were employed as cleaners on K2 landing, where Ms Sweeting had been given a cell. They said they spoke with Ms Sweeting, asked her why she had been imprisoned, and tried to welcome her. The women said that Ms Sweeting looked shocked by her situation so they told her that if she needed anything, she could ask them.

39. On 30 May, Ms Sweeting completed an induction during which she signed various compacts and staff provided her with information about the prison regime. The officer, who completed the induction, recorded no concerns about Ms Sweeting's well-being or appearance.

40. An officer recorded on the ACCT document that Ms Sweeting had an unsettled night over 30-31 May, and had said she had been having nightmares. He recorded no concerns about self-harm.

41. On 1 June, Ms Sweeting received a visit from her solicitor. When she returned to the wing afterwards, an officer recorded on the ACCT document that Ms Sweeting was upset. He told the investigator that Ms Sweeting had not said anything to him initially, but he had spoken with her after the visit. He said that Ms Sweeting talked about her charges, and that her solicitor had told her that her legal position was serious. He said that Ms Sweeting was not crying, but it was clear that she wanted to be left alone, and was quite withdrawn.

42. The officer recorded in the ACCT document that he had provided Ms Sweeting with the Samaritans phone at the same time. When interviewed, he could not recall exactly when he had done this, and thought that it may have been later on that day. However, two prisoners recalled going to Ms Sweeting's cell in the morning, just as she finished her phone call. They said that she was crying and heard her say "for fuck's sake, are you fucking serious, I am in prison". Prisoner A said that Ms Sweeting then hung up and threw the phone on the bed. When asked what was wrong, Ms Sweeting replied, "they won't speak to me because they think I am drunk". She said that she asked Ms Sweeting if she had taken any drugs, as she appeared as if she was under the influence. She described Ms Sweeting as "leaning against the door, with both her hands, and swaying". Ms Sweeting denied taking anything illicit and said that it was because she was tired and had not slept for days.

43. Ms Sweeting then began saying she had let her family down. Prisoner A claimed that Ms Sweeting then said, "I want to kill myself". She told the investigator that she did not report these comments to any member of staff, but had mentioned to staff that she thought Ms Sweeting might have taken something.

44. During the early afternoon, nursing staff visited Ms Sweeting on the wing to take blood samples and record her observations. A nurse checked Ms Sweeting's pulse and temperature and said that these were all within a normal range. He said Ms Sweeting had appeared over-sedated as she was "nodding off" and was "in and out" of conversation as he was checking her.

45. The nurse mentioned to his colleague that he thought Ms Sweeting might be over-sedated, but her clinical observations were within the normal range. When Ms Sweeting attended for medication that afternoon at 5.00pm, she did not present as over-sedated, and a nurse dispensed her methadone. Nursing staff also issued Ms Sweeting with her prescribed chlordiazepoxide at 5.30pm and 9.30pm.

46. On the evening of 1 June, a nurse was issuing late medications. He said that he began the medication round on Kinnon Unit at around 9.30pm. He said that when he arrived at the cell occupied by Ms Sweeting, to issue her with chlordiazepoxide, he noted she appeared to be in some discomfort. He said that she was holding her stomach and sitting on a chair.

47. The nurse asked what was wrong and Ms Sweeting said that she had felt sick all evening. Ms Sweeting then went to the toilet and he said that he lost sight of her, but could hear retching noises. He said that he had two other people still to issue medication to, so decided to complete these, and returned to Ms Sweeting around five minutes later. He told the investigator that he could still not see Ms Sweeting, so radioed for the assist orderly officer to come and unlock the door.

48. The nurse said that it took around 10 minutes for the assist orderly officer to arrive, and he then went into Ms Sweeting's cell. He said that Ms Sweeting had returned from the bathroom area and was sitting down when he went into the cell. She said that she had felt ill all evening and thought that it may have been something she had eaten. He said that he checked the toilet to see whether Ms Sweeting had vomited blood, but she had flushed the pan.

49. The nurse said that he checked Ms Sweeting's temperature, oxygen saturation and heart rate, which were all within the normal range. He gave Ms Sweeting her chlordiazepoxide, but said that she immediately vomited it back up. Ms Sweeting said that she was tired and he said that he advised her to sleep on her side and if she continued to feel unwell, then she should notify the staff.

50. The nurse told the investigator that, although nursing staff were no longer checking Ms Sweeting at night, he decided that he would look in on her 'informally' as he checked other women. He said that he was also aware that Ms Sweeting was on an open ACCT. He said that he estimated that Ms Sweeting was observed around 15 to 20 times during the night by both nursing staff and prison staff. He said that each time he looked in on Ms Sweeting she was snoring. He said that the last time he checked on her was between 5.30am and 6.00am, and he had no concerns.

51. Ms Sweeting was on an open ACCT document and staff were required to observe her a minimum of three times each hour. Between 12.00am and 7.20am on 2 June, 22 checks were recorded as being made on Ms Sweeting, carried out by officers and once by the nurse.

52. At 6.59am on 2 June, an officer checked on Ms Sweeting and noted that she was not snoring, as he said she had been during the other occasions he had checked. He said that she was fully clothed and lying on her front on top of the bed covers. He said that he noted that Ms Sweeting had moved since he had last checked her, and went along the landing to check on two other women. He

said that he then returned to Ms Sweeting's cell for his "own peace of mind" because she was no longer snoring as before. This time he called her name, but got no response. He said that he then left the landing and got a broom handle from the office and returned to Ms Sweeting's cell. He then put the broom handle through the observation hatch and banged the handle on the cell wall, in an attempt to gain a response. He received no response and then left the landing at 7.02am, before returning with a nurse at 7.04am.

53. A healthcare assistant (HCA) and a nurse returned to Ms Sweeting's cell with the officer. The HCA said that, when she entered the cell, Ms Sweeting was face down on the bed, and she called her name as she felt for a pulse. She said that no pulse was present and 'coffee ground' vomit was present on the pillow. She then asked the officer to call an emergency code blue over his radio. The nurse remained with Ms Sweeting, while the HCA went to collect an emergency response bag.

54. The code blue call was recorded at 7.05am, with the control room phoning for an ambulance at 7.06am. Two nurses responded to the code blue. Cardiopulmonary resuscitation (CPR) was commenced and continued by nursing staff until paramedics arrived at 7.21am. Paramedics then continued treatment and were joined by Helicopter Emergency Medical Services (HEMS) at 7.30am. Ms Sweeting never regained consciousness and she was pronounced dead by a doctor from the HEMS team at 7.42am.

Contact with Ms Sweeting's family

55. Two officers were appointed as the prison's family liaison officers. Both went to the home of Ms Sweeting's mother at around 10.00am on 2 June to inform her of her daughter's death. Also present were Ms Sweeting's brother and sister. The officers spent some time with the family, answering their questions and offering support. The prison contributed to the funeral costs, in line with national policy.

Support for prisoners and staff

56. After Ms Sweeting's death, the Deputy Governor debriefed the staff involved in the emergency. He offered his support and that of the staff care team.

57. The prison posted notices informing other prisoners of Ms Sweeting's death on 2 June, and offering support. Staff reviewed all prisoners considered to be at risk of suicide and self-harm prevention in case they had been adversely affected by Ms Sweeting's death.

Post-mortem report

58. The Coroner has confirmed that Ms Sweeting's cause of death has been recorded as 'unascertained.' This indicates that no definitive cause has been identified. Toxicology tests, including those for new psychoactive substances, indicated that Ms Sweeting had not taken illicit drugs prior to her death and prescribed medication was within the therapeutic range.

Findings

Assessment of Ms Sweeting's risk of suicide and self-harm in reception

59. Prison Service Instruction (PSI) 07/2015, *Early days in custody*, requires reception staff to be alert to the increased risk of suicide and self-harm among new prisoners. Staff should examine the prisoner's PER, and any other relevant documents to identify any immediate needs and recorded risks. Ms Sweeting's PER indicated that she had previously self-harmed, and done so recently, while in police custody. The PER also noted that she had a history of mental illness and that this was her first time in custody. Reception staff at Eastwood Park correctly considered the information provided and considered other factors, such as Ms Sweeting's charge and her appearance. They concluded that she required additional support and monitoring and an ACCT was opened appropriately.

Assessment, care in custody and teamwork (ACCT)

60. Ms Sweeting was monitored under the ACCT suicide and self-harm prevention procedures from the day she arrived at Eastwood Park. PSI 64/2011 requires ACCT case reviews to be multidisciplinary, where possible, involving staff from relevant departments and services. It is mandatory for a member of healthcare staff to attend the initial case review, but this did not happen in Ms Sweeting's initial review. There were also inconsistencies in the ACCT monitoring carried out by staff. We make the following recommendation:

    The Governor should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidance, including:

    - **A multidisciplinary approach for all case reviews with continuity of case management and healthcare staff attending first case reviews.**
    - **Completing observations as directed by the ACCT document with the aim of satisfying themselves of the prisoner's well-being.**

61. PSI 64/2011 requires caremaps to reflect the prisoner's needs, level of risk and the triggers of their distress. Caremaps should aim to address issues identified in the ACCT assessment interview and later reviews, and consider a range of factors including health interventions, peer support, family contact, and access to diversionary activities. Each action on the caremap must be tailored to meet the individual needs of the prisoner, should aim to reduce risk, and should be time bound. There were three actions listed for Ms Sweeting, appropriate to address her immediate needs.

62. The ACCT indicated that prison staff should observe Ms Sweeting a minimum of three times each hour. The purpose of the checks is to ensure that the individual is well, although it might not be necessary to engage in conversation with them every time. It is a requirement for staff to record on the ACCT document each time that they carry out a check and the time that this was completed.

63. On the evening of 1 June and morning of 2 June, an officer and an Operational Support Grade (OSG) recorded 22 checks between them, from 12.00am until

7.20am. CCTV was provided to the investigator, which shows the landing and cell occupied by Ms Sweeting. Checking CCTV against the recorded checks has raised a number of concerns.

64. The cell occupied by Ms Sweeting has an observation panel that remained open during the night. Unless the occupant is standing in the cell, it is difficult for staff to see her without approaching the door and looking in. CCTV shows that on occasions, while both the OSG and officer were on the landing, they did not approach the cell door, yet recorded these occasions as ACCT checks. When asked about these checks, both staff members said that they were able to hear Ms Sweeting snoring, so were not concerned.

65. The CCTV also shows that some checks recorded as taking place, never actually happened. The ACCT lists a check at 5.30am, but CCTV shows no check taking place. Checks are recorded on the ACCT at 6.20am and 6.30am. CCTV shows no check at 6.20am and while the officer is on the landing at 6.31am, it is not clear from CCTV that a check is being completed.

66. No obvious check on Ms Sweeting is made after 5.56am until an officer goes to the cell at 6.59am. The OSG also recorded checks at 7.10am and 7.20am - after Ms Sweeting had been discovered and nurses had attended the cell. The investigator asked both the OSG and the officer about the discrepancies highlighted by the CCTV. Both staff said that they would never record checks they had not completed and could not explain the inconsistency. The OSG was also unable to explain why he had recorded checks even after a code blue had been called.

67. The investigator shared the serious concern about the quality of the ACCT checks and authenticity of the records with the Governor at Eastwood Park. The prison conducted an internal investigation and this resulted in a final warning being issued to the officer, and the OSG choosing to leave the Service. We are satisfied that the prison dealt with the concerns we raised.

68. Separately, we understand that the Governor has commissioned a review of processes and procedures on Kinnon Unit which will consider the recent deaths that have occurred on Kinnon Unit. We understand that the review will report in December. We welcome the commissioning of the review which we expect to consider whether there is learning to be drawn from this sad case and look forward to seeing its conclusions. In the meantime we make no additional recommendation on this matter.

Emergency response

69. When the officer checked on Ms Sweeting at 6.59am, he said that he could not hear her snoring as he had on his previous checks. However, he said that he did note that she had moved since last observed, and so went to check on two other women subject to ACCT monitoring procedures. He then returned to Ms Sweeting's cell to check again, before leaving the landing. He explained he did this check for his own "peace of mind".

70. When he failed to gain any response from Ms Sweeting, rather than alert staff immediately to his concerns, the officer left the landing and returned with a

broom handle. He then put this through the observation hatch in the door and banged it against the inside wall of Ms Sweeting's cell. At interview, he said that he was trying to get a response but did not want to wake the other women on the wing, which was his reason for deciding to use the broom handle to hit the wall, he saw nothing inappropriate with his actions. The fact that he even considered such actions and when interviewed said he could see no issue with it, is a concern.

71. When the broom handle failed to elicit a response from Ms Sweeting, the officer then left the landing to ask a nurse to come up to the cell. He was carrying a radio and a sealed pouch containing a cell key. He could, therefore, have radioed for assistance and/or entered the cell had he wanted to. He said that he knew daytime nursing staff were arriving for duty and would have keys, so he went to ask them to come and unlock the cell. He told the investigator that he had no concerns about Ms Sweeting at this point, in terms of her having self-harmed. Despite her non-responsiveness and his attempts to attract her attention, neither was he concerned about her well-being.

72. A healthcare assistant (HCA) and a nurse attended the cell with the officer and on approaching Ms Sweeting, they realised that something was wrong. No breathing was noted, no pulse could be felt and the HCA saw vomit on Ms Sweeting's pillow. At this point the officer called a medical emergency code blue at the request of the HCA.

73. CPR was started immediately with other nursing staff responding to the code blue and assisting with resuscitation attempts. The control room requested an ambulance on receipt of the officer's code blue call, in line with national Prison Service policy.

74. Paramedics arrived at Eastwood Park 7.21am and continued treatment, and were joined by a Helicopter Emergency Medical Service (HEMS) team at 7.30am. Efforts to resuscitate Ms Sweeting continued until she was pronounced dead at 7.42am.

75. Once nursing staff entered Ms Sweeting's cell and it was recognised that there was an issue, nursing staff reacted promptly and appropriately in administering CPR. Emergency equipment was made available and emergency services were requested immediately.

76. While we cannot be certain whether or not earlier intervention would have changed the outcome for Ms Sweeting, we consider that the officer could have alerted nursing staff much sooner. He said that he had no concerns about Ms Sweeting, but was concerned enough to go off the landing to fetch a broom handle to try and elicit a response, an action in itself we consider to be highly inappropriate. This was after he had already been calling to Ms Sweeting and banging the door, both of which had failed to rouse her. The concerns regarding the officer's actions on 2 June were immediately shared with the Governor at Eastwood Park. We are satisfied that the prison has dealt internally with the actions of the officer and would expect the review of Kinnon Unit commissioned by the Governor to consider whether broader issues exist and if so what action may be required. We draw these matters to the attention of the Deputy Director

of Custody for the Women's Estate. We therefore make no additional recommendations.

Clinical care

77. When interviewed, a nurse told both the investigator and clinical reviewer that after he had seen Ms Sweeting at 10.00pm on 1 June, he then checked on her several more times during the night. He described these checks as 'informal' and even recorded on the medical records that he had last checked on Ms Sweeting at 5.30am, when she had been asleep and snoring. CCTV footage shows that the claims by the nurse are incorrect. He only checked on Ms Sweeting on one occasion, at 3.21am, when he can been seen looking into the cell via the observation hatch. When the investigator challenged him about his original account, he said that on reflection he had been mistaken and had not checked on Ms Sweeting as frequently as he had thought.

78. The clinical reviewer comments on this in his report and states that the nurse made notes following Ms Sweeting's death, outlining his observation and care of her that are, at least in part, seriously inaccurate. His recall of events does not tally with the CCTV footage. The nurse said he believed that this was the result of him trying to remember what happened after a long and stressful shift, and then being mistaken.

79. The clinical reviewer says that, in view of this, there has to be doubt about the detail of the nurse's examination of Ms Sweeting when she presented as ill some nine hours before the notes were made. He says that he finds it hard to accept that physiological measurements could be recalled so accurately if other easier events to recall (such as the number and times of observation) can be mistaken. At interview, the nurse said that that his usual practice was to write clinical notes down on paper and enter them on to the computer later. No paper notes exist to confirm whether his examination of her in the cell at 10.22pm on 1 June and 3.21am on 2 June from outside the cell has been accurately recalled. Therefore, the clinical reviewer says that the note made on SystmOne cannot be relied upon as fact. Ms Sweeting was seen to be ill before she died, and he does not believe that he can be certain of the nature of that illness.

80. The Nursing and Midwifery Council recommends that nurses should "complete all records at the time or as soon as possible after an event, recording if the notes are written some time after the event". The nurse could have made clinical records soon after he saw Ms Sweeting on the 1 and 2 June, or kept the paper records which he may have made. He did not do so.

81. Prison officers and the nurse recall Ms Sweeting being seen asleep when she was observed and they heard her snoring loudly. The clinical reviewer says that it is impossible to know whether that snoring was in reality obstructed breathing.

82. The clinical reviewer also states in his report that other assessments due during the first five days of Ms Sweeting's detoxification programme, were either not done, or not recorded. He concludes that with respect to clinical note making, the care of Ms Sweeting was far below the level of care she would have received in the community.

83. The clinical reviewer says that all clinical staff should be reminded that notes should be made as close to the time of contact with the patient as possible, and if transfer to SystmOne is not possible then the paper notes should be retained. The transfer of information to the electronic clinical system should be a systematic process, which sits within the normal working environment. The following recommendation is made:

The Director of Nursing for the healthcare provider should provide assurance to the commissioners that this process is robust and working.

84. The nurse's claims that he had seen Ms Sweeting during the night and the entries to that effect that he made on SystmOne are a serious breach of medical guidelines. The clinical reviewer reported the actions of the nurse to the healthcare commissioners as soon as they became known.

85. The Clinical Director for Bristol Community Health has confirmed that a letter has been sent to the nurse advising him that he would not be employed by Bristol Community Health in the future. The agency that had employed him were also contacted and told of the concerns and actions taken against him. A referral has also been made to the Nursing and Midwifery Council (NMC) regarding his actions.

86. The Coroner was unable to establish any definitive reason for Ms Sweeting's death and has recorded the cause as 'unascertained'. Had ACCT and clinical observations been conducted appropriately, then it is possible that an earlier intervention might have led to a different outcome for Ms Sweeting.

Prisons & Probation Ombudsman
Independent Investigations

PO Box 70769
London, SE1P 4XY

Email: mail@ppo.gsi.gov.uk
Web: www.ppo.gov.uk

T | 020 7633 4100
F | 020 7633 4141