Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Ms Natasha Chin a prisoner at HMP Bronzefield on 19 July 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*

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.

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

Ms Natasha Chin was found unresponsive in her cell at HMP Bronzefield on 19 July 2016. She was 39 years old. I offer my condolences to Ms Chin's family and friends.

Ms Chin died less than 36 hours after she arrived at Bronzefield. She had a history of substance misuse and was appropriately prescribed drug and alcohol withdrawal medication. On the night of 19 July, staff found her unresponsive in her cell and paramedics pronounced her death shortly afterwards. The post-mortem examination found that she died as a result of acute heart failure, myocardial scarring and cocaine toxicity.

Ms Chin's death was sudden and unexpected and I do not consider that staff could have prevented it. I am concerned about the robustness of night time healthcare checks on prisoners withdrawing from substances, but am otherwise satisfied that the clinical treatment Ms Chin received was appropriate.

It is important that prisoners are able to communicate with staff when they are locked in their cell. It is very regrettable that faults with the cell bell system meant that staff did not respond to Ms Chin when she rang her cell bell during the evening of 19 July. We cannot know why Ms Chin pressed her cell bell or whether the outcome might have been different for her had staff spoken to her.

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 **July 2017**

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Summary

Events

1. Ms Natasha Chin was released from prison on licence in April 2016. On 18 July, she was recalled to prison for breaching her licence conditions and was taken to HMP Bronzefield. Ms Chin tested positive for a number of illicit drugs. She was moved to the prison's drug detoxification unit and was prescribed methadone for opiate withdrawal and medication for alcohol withdrawal. Ms Chin told staff that she felt unwell due to substance withdrawal, but she reported no particular health concerns. Her pulse and blood pressure were taken and although her blood pressure reading was slightly high, it was not of sufficient concern to require action. Officers and nurses checked Ms Chin seven times overnight, and noted that she appeared to be asleep.

2. The next morning, Ms Chin failed to attend the healthcare room for her morning observations. A nurse later assessed her and noted that she had some mild drug withdrawal symptoms. She remained in her cell for most of the day. In the afternoon, an officer spoke to a nurse on duty because Ms Chin had been sick in her cell and seemed unwell due to withdrawal symptoms.

3. At 6.30pm, Ms Chin was taken to collect her evening medication and was then locked in her cell for the night. The cell bell system was not working properly. At 7.08pm, Ms Chin rang her cell bell. The officer on duty did not know that the system was not working properly and inadvertently checked on another prisoner in a different cell. There is no evidence that Ms Chin rang her cell bell again or tried to call for help in any other way.

4. A healthcare assistant looked into Ms Chin's cell at 9.24pm and thought she was asleep. Ms Chin was found unresponsive in her bed at 10.42pm when a nurse went to give her more medication. Staff began trying to resuscitate Ms Chin five minutes after they found her unresponsive. At 11.21pm, paramedics confirmed that Ms Chin had died.

Findings

5. The post-mortem report gave the cause of Ms Chin's death as acute heart failure, myocardial scarring and cocaine toxicity. The toxicology results found therapeutic levels of Ms Chin's prescribed medication and cocaine, consistent with her using it before her arrest.

6. The clinical reviewer confirmed that when Ms Chin arrived at Bronzefield, she had appropriately received a full health assessment and was prescribed appropriate medication for opiate and alcohol withdrawal. As Ms Chin was housed in the detoxification unit, she was subject to healthcare checks at night. Yet, these amounted to no more than observing the prisoner through the cell door. The healthcare assistant, who checked Ms Chin an hour before she was found unresponsive, could not be sure that she was breathing when he checked her. We are concerned that the procedures for checking prisoners on the detoxification unit at night are not sufficiently robust to ensure prisoners' safety at what is a particularly risky period.

7. When Ms Chin rang for help shortly after 7.00pm, the officer on duty had not been told that the cell bell system was not working properly. Although the officer knew that a prisoner had pressed the cell bell and became aware that there was a fault with the system, she checked a different cell in error which meant that Ms Chin's call for assistance remained unanswered.

8. We do not know why Ms Chin pressed her cell on the evening of 19 July, or whether it might have changed the outcome if the officer on duty had known the system was faulty, understood the back-up process and responded to Ms Chin's call. We consider that staff must be aware when there is a problem with the cell bell system and what to do in those circumstances.

9. We are concerned about the delay in starting resuscitation efforts when Ms Chin was found.

Recommendations

- **The Head of Healthcare should ensure there is clear guidance outlining procedures for checking prisoners withdrawing from drugs or alcohol at night, including ensuring that the prisoner is alive, and taking observations if they are deemed clinically necessary.**
- **The Director and Head of Security must ensure that all staff are told immediately about any malfunction in the cell bell system and know what to do in such circumstances.**
- **The Director and Head of Healthcare should ensure that:**
  - **there is annual staff training in basic life support; and**
  - **the most appropriately skilled member of nursing staff should start cardiopulmonary resuscitation immediately and should arrange for others to collect any necessary resuscitation equipment.**

The Investigation Process

10. The investigator issued notices to staff and prisoners at HMP Bronzefield informing them of the investigation and asking anyone with relevant information to contact him. No one responded.

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

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

13. The investigator interviewed twelve members of staff and four prisoners at Bronzefield in August 2016. The clinical reviewer joined him for some staff interviews.

14. We informed HM Coroner for Surrey of the investigation. We have sent the coroner a copy of this report.

15. One of the Ombudsman's family liaison officers contacted Ms Chin's family to explain the investigation and to ask if they had any matters they wanted the investigation to consider. Ms Chin's family had no specific questions for us to consider.

16. In response to the interim report, the solicitors representing Ms Chin's family said that the family had not raised any specific questions for consideration during the investigation, as they had not had access to relevant documentation during the investigative process. We have addressed a number of other issues raised by the solicitors on behalf of Ms Chin's family in separate correspondence.

Background Information

HMP Bronzefield

17. HMP Bronzefield is a privately managed local prison in Surrey, which holds up to 572 women. It is run by Sodexo Justice Services. Sodexo provides 24-hour primary nursing and inpatient care and Cimarron UK provides GP services.

HM Inspectorate of Prisons

18. The most recent inspection of HMP Bronzefield was in November 2015. Inspectors reported that over 40 per cent of prisoners indicated that they had a problem with drugs. Despite this and other challenging issues, inspectors said that the prison was a very good and improved prison, with staff culture that emphasised decency and professionalism. Inspectors reported that support for new prisoners was good and for those with substance misuse problems, some of the best inspectors had seen. They said that health services were reasonably good, and the substance misuse recovery unit provided a caring and well-managed environment, and helped women stabilise.

Independent Monitoring Board

19. 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 July 2016, the IMB reported that Bronzefield was well maintained and modern establishment and had witnessed staff providing care above and beyond which would be expected.

Previous deaths at HMP Bronzefield

20. Ms Chin was the seventh prisoner to die at Bronzefield since 2010, and the sixth to die from natural causes. There were no significant similarities between the circumstances of Ms Chin's death and the other deaths. However, our report into the death of a woman at the prison in 2011 concluded that prisoners undergoing methadone maintenance programmes should be checked regularly if they report as unwell.

Key Events

21. Ms Natasha Chin received over fifty convictions for mainly minor offences between 1995 and 2016. She had served a number of prison sentences, including at Bronzefield. Ms Chin had a history of significant drug misuse and many of her offences were committed to fund her drug use.

22. Ms Chin was remanded to HMP Holloway in 2013, charged with robbery, and was later sentenced to five years in prison. She was released on licence on 27 April 2016. Ms Chin's licence was revoked on 15 July 2016, for breaching her licence conditions. Her offender supervisor noted that a period in custody would give Ms Chin another opportunity to address her drug use as she had done during previous periods in prison.

18 July

23. At 5.35am on 18 July 2016, Ms Chin was detained at a police station for breaching her licence. She told police that she had no physical or mental health conditions but had recently cut herself. She said she had not self-harmed for 20 years and did not feel suicidal. Ms Chin said she was very tired, had drunk an excessive amount of alcohol and had taken heroin and crack cocaine a few hours earlier.

24. At 6.01am, police officers completed a risk assessment. They noted that while Ms Chin did not appear unwell or drunk, they agreed to check on her every 30 minutes and they placed her in a cell with closed circuit television.

25. Ms Chin was transferred to HMP Bronzefield that afternoon, and arrived at 3.15pm. A senior officer saw Ms Chin in reception. She said she could tell that Ms Chin was withdrawing and asked if she had brought any drugs with her. Ms Chin told the officer that she had not brought anything that she should not have, was withdrawing from drugs and wanted to lie down. Ms Chin was searched in line with prison searching procedures.

26. An officer completed a first night reception interview with Ms Chin. Ms Chin said that she had harmed herself earlier in the week because she was "pissed off", but had no current thoughts of self-harm. He sought the senior officer's advice about Ms Chin's risk. They agreed that Ms Chin was not at risk of self-harm and there was no need to monitor her under suicide or self-harm prevention procedures. They did not identify any immediate needs. The senior officer noted that Ms Chin was aware of Bronzefield's procedures. Ms Chin declined the opportunity to make a telephone call and said her family did not know she was in prison.

27. At an initial health screen, Ms Chin tested positive for a number of illicit drugs including benzodiazepines, cocaine, cannabis and opiates. The nurse who assessed Ms Chin said she was restless and did not want to talk. She said that Ms Chin had withdrawal symptoms and questioned when she would receive methadone. She said Ms Chin did not have severe withdrawal symptoms and looked fit and well.

28. Ms Chin was taken to a cell in the prison's detoxification unit. Later that afternoon, a prison GP, assessed her. While she had no concerns about her physical health, he noted her drug withdrawal symptoms. He approved the standard methadone treatment for opiate withdrawal. He prescribed chlordiazepoxide, a tranquilliser, and vitamins for Ms Chin's alcohol withdrawal.

29. At 8.45pm, an officer checked Ms Chin and noted that she was lying on her bed. The officer checked on her five more times that night and noted that Ms Chin appeared to be asleep on her bed.

30. Ms Chin received her first dose of methadone at midnight. A nurse checked on Ms Chin at 2.04am and 5.25am, and noted that she appeared to be sleeping.

19 July

31. Shortly after 8.00am, Officer A unlocked Ms Chin's cell. She said Ms Chin was lying on her bed awake. She said it was obvious Ms Chin did not feel well. She said Ms Chin's face looked puffed, but this was normal for newly arrived prisoners who were undergoing detoxification. She said that Ms Chin was coherent but very drowsy and did not collect her breakfast.

32. Just after 9.00am, Nurse A went to Ms Chin's cell, as she had not turned up for her morning observations. She said Ms Chin was sitting on her bed and looked tired and a little dishevelled. Ms Chin told the nurse that she was tired, as she had not slept well. She walked Ms Chin to the observation room. She said Ms Chin was steady on her feet and was coherent. She assessed that Ms Chin had mild withdrawal symptoms. She took Ms Chin's observations, which were within the normal range. She noted that Ms Chin's blood pressure was a little high, three points over the level, which indicated that methadone should not be administered.

33. Nurse A passed a note to her colleague, Nurse B, who was dispensing methadone that morning. It said that Ms Chin's blood pressure was slightly high and that she would check it again if Nurse B thought that it necessary before giving Ms Chin methadone. Ms Chin did not wait to collect her medication and returned to her cell.

34. Nurse B confirmed that Ms Chin did not collect her methadone at the medication hatch. She said she had not been aware that Ms Chin had been prescribed methadone (as she did not read Nurse A's note). She did not recall if either SystmOne, the electronic medical record, or the Metha-Measure methadone machine had highlighted that Ms Chin had not collected her methadone or whether she had asked officers to check on Ms Chin to see whether she would collect her medication, as was the routine practice.

35. Officer A said Ms Chin did not raise any health concerns that morning, other than that she felt sick. Ms Chin did not collect her lunch but another prisoner took her some. After lunch, Ms Chin was locked in her cell and slept for most of the afternoon.

36. In the afternoon, the prison chaplain completed Ms Chin's induction. Ms Chin said she had no family support and felt unwell. The chaplain noted that Ms Chin was quite rude. An officer checked on Ms Chin's welfare. He said Ms Chin sat

up in her bed and he introduced himself. He said Ms Chin, who looked as if she had flu, told him that she felt ill and did not want to answer any questions, but wanted to be left alone.

37. Officer A said that during the afternoon, she became aware that Ms Chin had been sick a number of times. At around 4.00pm, she told Nurse C that Ms Chin might need some medication to stop her feeling sick. The officer and another prisoner cleaned Ms Chin's vomit from a bowl Ms Chin had used. The officer said it was not unusual for women who were undergoing detoxification to have these experiences.

38. At 4.41pm, Ms Chin left her cell but returned two minutes later. At 5.23pm, she left her cell again. Officer A said that Ms Chin spoke to her at the servery. The officer described Ms Chin as looking unwell and puffed. Ms Chin said she did not want her evening meal, but asked for a biscuit. She gave Ms Chin a biscuit and a yoghurt. Between 5.30pm and 6.00pm, a number of prisoners visited Ms Chin in her cell. At 5.38pm, Officer A visited Ms Chin and later asked Nurse C to see Ms Chin because she was worried about her.

39. A number of women prisoners said it was obvious Ms Chin was not well. Three prisoners described how Ms Chin's face and tongue were swollen and that she found it difficult to breathe. Another said that nurses had noticed that Ms Chin's appearance was different from the photograph on her identity card. They did not recall the identity of the nurses. (Anecdotally, a prisoner said she thought that Ms Chin had brought concealed drugs in to the prison with her.)

40. At around 6.00pm, following Officer A's request, Nurse C arrived at Ms Chin's cell, saw Ms Chin had vomited in a bowl and asked how she was feeling. The nurse said Ms Chin told her that she had not taken her methadone, as she had been asleep. She asked Ms Chin if she could walk, and Ms Chin confirmed that she could.

41. Just before 6.30pm, Officer A and a colleague unlocked Ms Chin to take her for her medication. Officer A said that, when Ms Chin was told it was time for her to take her methadone, she moved more quickly than she had earlier that day.

42. Nurse A said that towards the end of the medication round, an officer (who she could not recall) told her that Ms Chin had not taken her morning methadone. She took Ms Chin's observations, which she said were within normal limits, but did not record them in her medical record. The nurse said that Ms Chin did not report any withdrawal symptoms. She looked tired, but not worryingly ill and was able to walk and talk coherently.

43. Nurse C gave Ms Chin her prescribed methadone, other medications and some anti-sickness medication. She said that Ms Chin did not complain of any distress or pain. Officer A locked Ms Chin in her cell.

44. At 7.08pm, Ms Chin rang her cell bell. Officer B, who was the only officer on duty on the houseblock at that time, was unaware that the cell bell system was not working properly. She was in the centre office and said she heard a strange buzzing noise from the cell bell control console, which was not the usual cell buzzer sound she expected. She said she noticed that the cell bell TV monitor

was not working, but that the telephone linked to it briefly showed a cell number. She said that when trying to work out what to do, she may accidentally have pressed the cancel button. She immediately went back to the cell she had thought had called her, cell D5. (In fact it was Ms Chin, who was in cell C5, who had called.) She spoke to the prisoner in cell D5, and asked if she had rung her cell bell. That prisoner said that she had and asked for a lighter. She went to cell D5 and gave the woman a lighter.

45. When she returned to the centre office, Officer B reported the faulty cell bell system to the control room. She said that the control room were shocked that she did not know that the system had not been operating fully during the day.

46. Nurse C gave the night nurse, Nurse D, a handover at around 8.30pm. Nurse D said she was told that Ms Chin had been feeling unwell earlier in the day, had been sick, was withdrawing quite badly, had missed her methadone that morning but had received it at 6.30pm. Nurse C told Nurse D that Ms Chin would need to be checked during the night.

47. Officer C arrived on the houseblock at around 8.30pm. The officer said Officer B gave him a handover, but had not mentioned Ms Chin. At 8.54pm, Officer C looked through Ms Chin's cell observation panel as part of his roll check. He said Ms Chin did not ring her cell bell that evening and no one expressed any concerns about her.

48. At 9.24pm, a healthcare assistant (HCA) checked on Ms Chin. He said that she was lying on her side and appeared to be asleep.

49. At 10.42pm, Nurse D went to Ms Chin's cell to give her medication. The HCA and an officer went with her. The cell door was opened and Nurse D said the HCA went in to wake Ms Chin, but she did not respond. Nurse D said that she then touched Ms Chin to wake her, and noticed that her skin was cold. She and the HCA checked for Ms Chin's pulse but found none. She said there was no sign of breathing and in her opinion, Ms Chin was dead. The officer called an emergency code blue (used when prisoners are not breathing). An ambulance was called within a minute of the code blue but it took three more minutes before the ambulance service answered the call.

50. At 10.43pm, Nurse D left the cell to fetch the emergency response bag. On the way, she told Officer C that she thought Ms Chin was dead. Nurse D returned to the cell but left a short time later to get the defibrillator. She returned at 10.47pm. The defibrillator was attached and advised to start chest compressions. Nurse D, Officer C and the HCA tried to resuscitate Ms Chin, with support from other members of the healthcare team. Paramedics arrived and took over resuscitation efforts at 11.17pm. At 11.21pm, the paramedics confirmed that Ms Chin had died.

Contact with Ms Chin's family

51. Two officers were appointed as family liaison officers. After seeking advice from the police, they tried unsuccessfully to visit Ms Chin's mother the next morning, but no one was home and she did not answer the phone number they had for her. At 12.20pm, they made contact with Ms Chin's sister and broke the news of Ms

Chin's death. Bronzefield contributed to the cost of Ms Chin's funeral in line with national policy.

Support for prisoners and staff

52. A manager debriefed the staff involved in the emergency response and offered support. The prison notified other prisoners of Ms Chin's death and offered support. Officers reviewed prisoners assessed as at risk of suicide and self-harm, in case they had been affected by the news of Ms Chin's death and staff, including the chaplain and members of the IMB, offered support to prisoners affected by Ms Chin's death.

Post-mortem report

53. The results of the post-mortem examination gave the cause of death as acute heart failure, myocardial scarring and cocaine toxicity.

54. Toxicology tests showed low concentrations of Ms Chin's prescription drugs which were consistent with therapeutic levels. A low concentration of cocaine was also detected. This was consistent with cocaine use before Ms Chin's death, and probably before she was arrested. There was no evidence that Ms Chin had taken cocaine in prison before she died.

Further information from the clinical reviewer

55. After we shared our initial report with Ms Chin's family, they had questions about her presentation. We asked the clinical reviewer for further information and he said, "**if** Ms Chin did have actual facial swelling (oedema) that this is not a recognised sign of opiate withdrawal". He added that Ms Chin's profuse vomiting may have contributed to her puffy face. He said that facial swelling was not usually a feature of heart failure, but taken with difficulty breathing, should have provoked further investigation by the medical team. He noted that the nurses had denied Ms Chin was short of breath when she walked to collect her methadone and that they seemed unaware of facial puffiness. He concluded that it was most likely that Ms Chin had pre-existing opiate-related cardiac damage and probably experienced heart failure as a result of withdrawal.

Findings

Clinical care

56. Ms Chin had been at Bronzefield for less than 36 hours when she died. The clinical reviewer concluded that a nurse and GP assessed her fully and appropriately when she arrived. They identified her history of substance misuse, that she had some withdrawal symptoms and prescribed the appropriate medication for opiate and alcohol withdrawal. Ms Chin complained of and displayed no other serious health problems.

57. The clinical reviewer noted that Ms Chin's blood pressure was taken twice, and on both occasions, was slightly high. He found that she had a history of slightly high blood pressure readings on reception to prison, which normally settled within a few days. He did not conclude that the readings were so high that they should have caused alarm or further investigation.

58. Healthcare staff check prisoners on the detoxification unit at night during their first five days of detoxification. The checks are carried out by observing the prisoner through the observation panel in the cell door. Healthcare staff do not take any observations at night. The HCA checked Ms Chin just over an hour before she was found unresponsive. He recorded that she appeared to be asleep but agreed at interview that he could not confirm whether or not she was breathing at that check. The clinical reviewer queried whether observing prisoners through the observation panel was sufficiently robust, given that the early days in prison were recognised as a particularly risky period for prisoners withdrawing from substances. We recommend that:

    The Head of Healthcare should ensure there is clear guidance outlining procedures for checking prisoners withdrawing from drugs or alcohol at night, including ensuring that the prisoner is alive, and taking observations if they are deemed clinically necessary.

59. The clinical reviewer raised issues about the recording of medical interventions, assessments and prescriptions in medical records. These had no direct impact on Ms Chin's death, which was sudden and unexpected, and we make no recommendations. Nevertheless, we agree with his findings, which the Director and Head of Healthcare at Bronzefield will need to address.

Cell bell system malfunction

60. When Officer B started work on the evening of 19 July, no one had told her that the cell bell system was not working properly and she did not know how the back-up system worked. When Ms Chin rang her cell bell at 7.08pm, she realised the system was faulty and tried to answer the call. In error, she misread the calling cell number and responded to another prisoner in a different cell who said that she had pressed her cell bell. She dealt with the prisoner's request and was not aware of the error made. She reported the fault to the staff in the prison's control room, who were already aware of the fault. There is no evidence that Ms Chin pressed her cell bell again that evening, or sought help in any other way.

61. We cannot know why Ms Chin pressed her cell bell and cannot say whether the outcome would have been different for Ms Chin if Officer B had responded to her that evening.

62. After Ms Chin's death, the Director of Bronzefield re-issued and reminded staff of the procedures in place to deal with a cell bell system failure. While we recognise that Bronzefield has already taken action, it is critical that prisoners are able to communicate with staff, particularly when they are locked in their cells, and we make the following recommendation:

The Director and Head of Security must ensure that all staff are told immediately about any malfunction in the cell bell system and know what to do in such circumstances.

Resuscitation

63. When Nurse D assessed Ms Chin at 10.42pm on 19 July, she thought she was dead. The nurse said that she was not qualified to confirm death and was required to attempt resuscitation. Yet, she twice left Ms Chin's cell to collect emergency medical equipment and no one began resuscitation efforts until she had attached the defibrillator five minutes after Ms Chin was found.

64. The clinical reviewer noted that healthcare staff should understand the circumstances in which it is appropriate to attempt resuscitation. He concluded that as Nurse D, the most senior nurse present, thought that resuscitation was appropriate, she should have initiated it immediately and sent the HCA to collect the emergency equipment.

65. The clinical reviewer noted though that in the circumstances it is highly unlikely that even if staff had begun resuscitation efforts immediately, the outcome would have been different for Ms Chin. We make the following recommendations:

The Director and Head of Healthcare should ensure that:

- **there is annual staff training in basic life support; and**
- **the most appropriately skilled member of nursing staff should start cardiopulmonary resuscitation immediately and should arrange for others to collect any necessary resuscitation equipment.**

Prisons & Probation Ombudsman
Independent Investigations

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Record of Inquest

Following an Investigation commenced on the 20 July 2016;
And an Inquest opened on the 29 July 2016;
And an Inquest hearing at Court Room 2, HM Coroner's Court, Station Approach, Woking, Surrey, England on the 29 November 2018, heard before Ms Caroline Topping in the said coroner's area and the undermentioned jurors:

The following is the record of the inquest (including the statutory determination and where required, findings)

1 Name of Deceased (if known)
Natasha Learline CHIN

2 Medical cause of death:

I a Cardiac arrest due to ventricular arrhythmias
I b Hypomagnezemia, hypokalemia and myocardial scarring
I c Chronic Cocaine Use

II Chronic alcohol abuse and/or dependence

3 How, when and where and for investigations where section 5 (2) of the Coroners and Justice Act 2009 applies, in what circumstances the deceased came by his or her death.

On 19th July 2016 Natasha Learline Chin died at HMP Bronzefield, Woodthrope Road, Ashford, Middlesex TW15 3JZ. Miss Chin was recalled to prison following a breach of licence. She had a history of serious drug and alcohol abuse. Between the hours of 09.14 and 18.36 on 19th July 2016,

a) The healthcare staff failed;
i) To ensure that Miss Chin had her prescribed medication when due;
ii) To escalate Miss Chin's failure to have her medication in accordance with policies;
iii) To undertake the opiate and alcohol withdrawal scales;
iv) To carry out any adequate assessments or observations and record them. Such assessments and observations would have enabled Miss Chin to receive, and have had adjusted, her medication;
v) To monitor her vomiting adequately or at all;
vi) To respond to the prison officer's request for help timeously;
vii) To put in place an adequate hand-over at lunchtime;
viii) To monitor the level of Miss Chin's hydration.

b) The operational staff failed:
i) To follow the escalation protocol for welfare concerns:
ii) To diligently record welfare concerns according to policy.

4 Conclusion of the Coroner as to the death
Miss Chin's death was caused or more than minimally contributed to by a systemic failure through poor governance which led to a lack of basic care.
The Death was contributed to by Neglect.
The death was caused or more than minimally contributed to by the failure on the part of the Sodexo Justice Services to:
i. Ensure the prompt administration of prescribed medication
ii. Ensure that the medical records were checked before clinical observations were undertaken or medication administered.

5 Further particulars required by the Births and Deaths Registration Act 1953 to be registered concerning the death

(a) Date and place of birth: **28 September 1976** **Westminster, Greater London**	
(b) Name and Surname of deceased: **Natasha Learline CHIN**	
(c) Sex: **Female**	(d) Maiden surname of woman who has married: **----------**
(e) Date and place of death: **19 July 2016** **Bronzefield, Woodthorpe Road, Ashford, TW15 3JZ**	
(f) Occupation and usual address: **----------,** **Bronzefield, Woodthorpe Road, Ashford, Middlesex**	

«AuthorisingUserSignature»
Signature of **«AuthorisingUserFullName», «AuthorisingUserAppointment»**

Signature of Jurors (if present)

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