

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Ms Kelly Quilt a prisoner at HMP Eastwood Park on 21 October 2018

A report by the Prisons and Probation Ombudsman

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 I oversee can improve their work in the future.

Ms Kelly Quilt died on 21 October 2018 in her cell at HMP Eastwood Park. The pathologist concluded that the cause of death was 'a sudden unexpected death due to the cessation of heroin and cocaine use'. Ms Quilt was 39 years old. I offer my condolences to Ms Quilt's family and friends.

Ms Quilt had only been at Eastwood Park for a couple of days when she was found dead. She had a long history of drug dependency and was withdrawing from drugs in the prison's substance misuse unit at the time of her death. I am satisfied that she was located appropriately and had received care equivalent to that she could have expected in the community.

However, I am concerned that there was a lengthy delay before staff went to inform Ms Quilt's family of her death.

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

Sue McAllister CB
Prisons and Probation Ombudsman

December 2019

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Summary

Events

1. Ms Kelly Quilt had a long history of drug dependency and had spent much of her adult life in prison. On 19 October, she was sentenced to 14 weeks imprisonment and sent to HMP Eastwood Park.
2. At Ms Quilt's reception health screen, a nurse recorded her drug dependency history and that she was experiencing mild opiate withdrawal. She was located on the detoxification wing and kept under observation.
3. During the afternoon of 20 October, Ms Quilt reported having spasms in her hand. A nurse observed her and noted that she appeared to have normal movement, strength and circulation. She consulted a GP who advised that Ms Quilt be kept under observation.
4. During the night, Ms Quilt told another nurse about her hands and asked for pain relief. The nurse gave her mild pain relief. She noted that Ms Quilt appeared to use her hands perfectly well when she did not realise she was being observed, and thought she might be trying to obtain stronger medication.
5. During the early hours of 21 October, the nurse observed Ms Quilt three times and reported no concerns.
6. At approximately 7.30am, an officer performed a roll check and reported no concerns. At approximately 9.05am, another officer found Ms Quilt unresponsive when he unlocked her cell. He thought she was clearly dead, so did not call an emergency medical code but went in person to fetch nurses who were working nearby.
7. The nurses concluded that Ms Quilt had been dead for some time and did not attempt to resuscitate her. At 11.20am, a prison GP confirmed her death.

Findings

Clinical care

8. We agree with the clinical reviewer that the care Ms Quilt received at the prison was equivalent to that which she could have expected in the community.

Emergency response

9. We accept that the officer who discovered Ms Quilt did not trigger an emergency response because he believed, correctly, that Ms Quilt had been dead for some time and was past the point of resuscitation. We consider, however, that the circumstances in this case were exceptional and that staff should normally err on the side of caution and call an emergency code if they find a prisoner unresponsive.

Family contact

10. We are concerned that an attempt was not made to inform Ms Quilt's family of her death until almost six hours after she had died.

Recommendations:

- The Governor should ensure that a member of Prison Service staff informs a prisoner's family or next of kin of their death promptly, in line with PSI 64/2011.

The Investigation Process

11. 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. No one responded.
12. The investigator obtained copies of relevant extracts from Ms Quilt's prison and medical records.
13. NHS England commissioned an independent clinical reviewer to review Ms Quilt's clinical care at the prison. The investigator and clinical reviewer jointly interviewed eight members of staff at Eastwood Park on 28 January 2019. The investigator interviewed a further member of staff on 29 January.
14. We informed HM Coroner for Avon of the investigation. The coroner gave us the results of the post-mortem examination and we have sent her a copy of this report.
15. The investigator wrote to Ms Quilt's son, to explain the investigation and to ask if he had any matters he wanted the investigation to consider. He did not reply.
16. We shared our initial report with HM Prison and Probation Service (HMPPS). They pointed out some factual inaccuracies which have been amended in this report. They also provided an action plan which is annexed to this report.

Background Information

HMP Eastwood Park

17. Eastwood Park is a closed prison in Gloucestershire, which can hold up to 442 women. It has 10 residential wings, two of which specialise in dealing with prisoners with substance misuse issues. The Kinnon Unit holds new prisoners who need detoxification treatment. Healthcare is provided by Inspire Better Health.

HM Inspectorate of Prisons

18. The most recent inspection of HMP Eastwood Park took place in May 2019 but the report has not yet been published.
19. The previous inspection was conducted in November 2016. Inspectors reported that care and support for prisoners was strong and the substance misuse strategy was well managed.

Independent Monitoring Board

20. 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 October 2018, the IMB reported that Eastwood Park was a well-run prison with staff and managers treating prisoners with professionalism and care.
21. The Board recognised the high number of women entering Eastwood Park with substance misuse problems and reported that the substance misuse team offered a wide range of services to help women overcome the medical and psychological barriers to becoming free from illicit substances. They observed that this involved rapid detoxification before long-term goal planning.

Previous deaths at HMP Eastwood Park

22. Ms Quilt was the second prisoner to die at Eastwood Park since the start of 2017. The previous death was from natural causes. There has been one death since, also from natural causes. There were no similarities between Ms Quilt's death and these other deaths.

Key Events

23. Ms Kelly Quilt had a long history of drug dependency and had spent much of her adult life in prison.
24. On 26 July 2018, she was released from HMP Foston Hall, where she had been taking methadone (an opiate drug used as a substitute for heroin). She was given a note to obtain a methadone prescription in the community.
25. On 19 October, Ms Quilt was convicted of theft and breaching a previous suspended sentence and sentenced to 14 weeks imprisonment and was sent to HMP Eastwood Park.

Admission to Eastwood Park

26. Ms Quilt was admitted to Eastwood Park shortly before 5.00pm. At 5.13pm, an officer recorded that Ms Quilt did not make a phone call on her arrival because she felt unwell from detoxing. She noted that Ms Quilt appeared tired during the induction interview due to withdrawing.
27. At 5.44pm, a nurse carried out Ms Quilt's reception health screen. He noted her drug dependency issues and that she had used drugs within the last three months. He recorded that Ms Quilt's urine tests were positive for heroin and cocaine, but negative for methadone. He recorded that she had a COWS score of 8. (The Clinical Opiate Withdrawal Scale, or COWS, is an 11-item scale used by clinicians to determine the severity of opiate withdrawal. A score of 8 indicates mild withdrawal.) The nurse noted that Ms Quilt was not fit for a normal cell location.
28. At 6.18pm, a prison GP reviewed Ms Quilt. He noted her daily cocaine and heroin use, and that she said she had last used drugs two days previously. Ms Quilt told the GP that she also used diazepam (a tranquiliser), but he noted that she had tested negative for this in her drug tests and that she demonstrated no obvious withdrawal symptoms (cramps, shaking, seizures) at that time. In interview, the GP said that he could see no signs of diazepam withdrawal when he reviewed Ms Quilt and that there was nothing else that caused him undue concern. He renewed Ms Quilt's prescription for methadone and metoclopramide (to prevent nausea and vomiting) and instructed that she should be monitored.
29. Ms Quilt was located on the Kinnon Unit, which served as the induction unit as well as the detoxification wing at Eastwood Park. In interview, a substance misuse nurse explained that staff on the unit monitor prisoners for the effects of withdrawal or other forms of clinical distress when they first arrive at the prison. During the night, a nurse recorded three observations of Ms Quilt. She reported no concerns.

20 October

30. On the morning of 20 October, a nurse administered Ms Quilt's medications. In interview, she said that Ms Quilt appeared alert and orientated and that she had no concerns.

31. At approximately midday, a healthcare assistant reviewed Ms Quilt. He recorded her COWS score as zero and reported no other concerns.
32. At 3.38pm, a nurse examined Ms Quilt, after Ms Quilt said that her hands were going into spasm. The nurse recorded that Ms Quilt had normal temperature and sensation, a full range of movement and strength, and good circulation. The nurse consulted the on-call GP, who advised her to keep Ms Quilt under observation over the weekend. The nurse said that she then gave Ms Quilt her medication at approximately 6.00pm and that she recalled nothing unusual after that. She said that at approximately 7.30pm, she handed over to nightshift staff and recorded the issue with Ms Quilt's hands on the handover sheet.
33. The nurse who covered that night shift on the Kinnon Unit said at interview that she received a handover which explained the concerns about Ms Quilt's hands and that the GP had advised for her to be monitored.
34. The nurse said that while she was doing her evening medication rounds, Ms Quilt called her over to her cell and asked for pain killers. The nurse said that Ms Quilt complained about her hands and said that she had been struggling with them since the Wednesday (17 October, three days earlier) but had not mentioned it during her reception health screen. The nurse gave her paracetamol but said that Ms Quilt asked for something stronger. She said that Ms Quilt struggled to take the tablets while holding a cup, so she placed them into her mouth through the cell observation hatch. The nurse said that she observed Ms Quilt, and she appeared to be using her hands normally when she did not realise that she was being watched. She said that she was wary because prisoners often 'put on' symptoms in order to get medication.
35. The nurse said that approximately an hour later, she saw Ms Quilt again at the request of prison officers. Ms Quilt requested more painkillers, so the nurse offered her ibuprofen because she had only taken paracetamol an hour earlier. The nurse said that she could not leave the ibuprofen with her due to the risk of hoarding, so Ms Quilt had to come to her cell door to take them. She said that Ms Quilt started to get out of bed and waved her legs about a bit, but there was no trembling so she did not appear to be having a seizure. The nurse said that Ms Quilt then walked over to the door without any apparent trouble and then said she did not want the ibuprofen and went back to bed. The nurse said that she suspected Ms Quilt might have been trying to get stronger different drugs. (She said that she was allowed to administer diazepam but only in emergency situations.)

21 October

36. The night shift nurse said that nurses observe all prisoners in the unit three times during the night. She recorded at 1.42am, 3.38am, and 5.25am that Ms Quilt appeared to be asleep and was breathing normally. In interview, she said that she could not be certain of the exact times of the observations as they were written up after the rounds on the unit, but she definitely did three observations and had no reason to be concerned about Ms Quilt.
37. On 21 October, an officer was on the early shift. In interview he said that at approximately 7.30am he performed the roll checks on the unit and would have

checked Ms Quilt's cell. The officer said that this involved looking through the observation panels to make sure that all prisoners were in their cells, but that there was not enough time to check for movement. He said that he did not note anything untoward, but would have acted on it if he had.

Emergency response

38. Shortly after 9.00am, an officer began unlocking the cells on Ms Quilt's landing. In interview, he said that he unlocked the first four cells on the landing before he reached Ms Quilt's cell. He did not get a response when he spoke to her, so went into her cell. The officer said that Ms Quilt appeared discoloured and stiff, so he touched her arm which was cold and stiff. He said that he believed that she was dead. The officer said that he left the cell, locked it, and then locked the four cells he had just opened. He said that he locked these cells because he did not want anyone to go into Ms Quilt's cell and find her.
39. The officer then walked to where the nurses were working, which he said was about 30 feet away. He told them that he believed a prisoner had died and asked them to check. He said that he had started to put a call out over the radio but had reached the nurses by the time he was connected to the net. The officer said that he did not call a code blue medical emergency because he believed that Ms Quilt was already dead and that rigor mortis had clearly set in. (A code blue call is an emergency radio code which indicates someone is unconscious or having problems breathing. It triggers the immediate attendance of healthcare staff and the control room to call for an ambulance.) The officer said that he returned with a nurse, who immediately confirmed that Ms Quilt was dead.
40. That morning, a nurse and healthcare assistant were getting ready to distribute medications from the pharmacy hatch on Kinnon Unit.
41. In interview, the nurse said that she was setting up the pharmacy clinic with the healthcare assistant when an officer came to the door and asked them to follow him. She said that when they entered Ms Quilt's cell, she was lying on her bed with her legs splayed out and her arms fixed with her fists clenched. The nurse said that it was very clear that Ms Quilt was dead: she was very cold, rigor mortis had set in and her skin was very waxy. She said that they checked for a pulse, but that it was clear that Ms Quilt had been dead for some time. She said that they then called over the radio for the senior healthcare manager to attend. The nurse said that there were no signs of drug use and no incontinence, blood or vomit.
42. In interview, the healthcare assistant said that the officer came to the medications hatch and asked them to go to Ms Quilt's cell. She said that when they arrived it was clear that rigor mortis had set in. They checked for a pulse but could not find one and so called for the medical emergency responder to attend.
43. In interview, the senior healthcare manager said that she heard a code blue call over the radio, but was not sure what time that was. The investigator asked whether she was sure, and she confirmed that she definitely heard a code blue call. She said that she attended but was not sure what time it was, and when she arrived at Ms Quilt's cell, a nurse and healthcare assistant were already

there. The senior healthcare manager said that it was clear that Ms Quilt was dead, so she asked the on-call GP to confirm her death.

44. At 11.20am, the on-call GP pronounced Ms Quilt dead.
45. Following Ms Quilt's death, three blister packs of medication were found in her cell. Some fluid was also detected in her bin which might have been vomit. Prisoners on her landing reported that she had been unwell due to detoxing and had been sick, but there is no evidence that she had reported this to prison or healthcare staff.

Post-mortem report

46. The post-mortem report noted that the three blister packs found in Ms Quilt's cell, contained what was thought to be mirtazapine (an antidepressant) and amitriptyline (which is used as a pain killer and as an antidepressant). Neither had been prescribed to Ms Quilt.
47. Post-mortem toxicology tests revealed no trace of opiates, cocaine or other illicit substances. There was also no trace of methadone (which could indicate Ms Quilt had been vomiting). Mirtazapine and amitriptyline were both detected, but at levels within a therapeutic range.
48. The post-mortem examination found no evidence of injury or of any significant injury or of any pre-existing natural disease that would have caused or contributed to Ms Quilt's death. The pathologist concluded that the exact cause of death was unclear, but that overall appearances were suggestive of a death associated with withdrawal from regular heroin and cocaine use. She recorded the cause of death as 'a sudden unexpected death following cessation of heroin and cocaine use'.

Contact with Ms Quilt's family

49. At 9.30am, following Ms Quilt's death, the prison appointed a supervising officer (SO) as her family liaison officer (FLO), with an officer as her deputy. At 10.15am, the FLO recorded that Ms Quilt had named a friend as her next of kin. She asked West Midlands Police whether they had any other next of kin details, and also whether the friend's address was safe to visit.
50. At 2.45pm, the FLO recorded that the police had provided an address for Ms Quilt's mother. She recorded the number of the house in the family liaison log as one digit different to the address recorded for the next of kin in Ms Quilt's prison record.
51. At 3.00pm, the FLO and her deputy arrived at the address the FLO had recorded. There was no answer so, after several times of trying, they checked with the next-door neighbour at 4.55pm. The neighbour said that they had the wrong house, and also that Ms Quilt's mother had died a few months ago but that three family members lived there. The correct address was the one recorded in Ms Quilt's prison record.
52. They tried several times, but could get no answer at this address. At 5.25pm, a man arrived at the house. They established that this was Ms Quilt's son and that

he lived there with his two brothers who were also Ms Quilt's sons. They informed him about his mother's death and offered to stay so they could inform his brothers when they returned home. Ms Quilt's son said that he did not want them to stay and that he would break the news to his brothers and other family members himself.

53. The FLO and her deputy left their contact details and offered support. The FLO kept in contact with Ms Quilt's son, and arranged for him to perform next of kin duties.
54. Later that evening, the police emailed the FLO to inform her that the address she had provided was safe to visit. The address recorded on the email was the same as the one in Ms Quilt's prison record, and the name related to one of her sons.
55. Ms Quilt's funeral was held on 27 November. The prison contributed to the cost in line with national guidance.

Support for prisoners and staff

56. After Ms Quilt's death, the duty governor 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.
57. The prison posted notices informing other prisoners of Ms Quilt'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 Quilt's death.

Findings

Clinical care

58. The clinical reviewer is satisfied that the care Ms Quilt received at Eastwood Park was equivalent to that she could have expected in the community. Healthcare staff appropriately managed her drug withdrawal and regularly observed her on the induction unit, including throughout the night shift when prisoners were locked up.
59. It is likely that Ms Quilt had been dead for some time when she was discovered shortly after 9.00am on 21 October. However, we have no reason to doubt that she was asleep and breathing normally as the nurse had recorded at 5.25am.

Emergency response

60. Prison Service Instruction (PSI) 03/2013, *Medical Response Codes*, requires prisons to have a two-code medical emergency response system in place. A code blue call should be used to indicate an emergency when a prisoner is unconscious, or having breathing difficulties, and code red when a prisoner is bleeding. Calling an emergency medical code should automatically trigger the control room to call an ambulance.
61. When the officer discovered Ms Quilt unresponsive in her cell, he did not immediately call a code blue emergency on the radio. We would normally be critical if a member of staff fails to do this because it creates a delay before medical help arrives. However, it is clear from the nurses' evidence that rigor mortis was present when Ms Quilt was found and that it would have been obvious, even to a lay person, that Ms Quilt was dead and past the point of resuscitation. Healthcare staff who saw Ms Quilt very shortly afterwards, confirmed that she had almost certainly been dead for some time and they did not attempt resuscitation. In these circumstances we accept, exceptionally, that it was not necessary for the officer to call a code blue.
62. We should make it clear, however, that these were exceptional circumstances and that we would normally expect staff to err on the side of caution and call a code blue if they find a prisoner unresponsive. We would never be critical of a member of staff for doing so.
63. We are satisfied that healthcare staff took the appropriate decision not to attempt resuscitation when they attended to Ms Quilt.

Family contact

64. Prison Rule 22(1) states: "If a prisoner dies, becomes seriously ill, sustains any severe injury or is removed to hospital on account of mental disorder, the governor shall, if he knows his or her address, at once inform the prisoner's spouse or next of kin, and also any person who the prisoner may reasonably have asked should be informed."
65. PSI 64/2011, *Safer Custody*, says that "wherever possible, the FLO and another member of staff must visit in person the next of kin or nominated person to break

the news of the death. Time will be of the essence in order to try to ensure that the family do not find out about the death from another source.”

66. We are concerned that there was a delay before Ms Quilt’s family were told she had died. We accept that prison staff needed to ensure that the address they were visiting was safe and that they had to rely on the police to perform these checks. However, they did not arrive at the address until 3.00pm, which was almost six hours after Ms Quilt died. This was in fact the wrong address; the house number was one digit different to the house number recorded for Ms Quilt’s next of kin in her prison record. When no one was there, they did not try the address they had on record and waited for almost two hours before trying a neighbour, who then gave them the correct address (the one they had had all along). We recommend:

The Governor should ensure that a member of Prison Service staff informs a prisoner’s family or next of kin of their death promptly, in line with PSI 64/2011.

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