

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Ms Samantha Brady-Bott a prisoner at HMP Eastwood Park on 6 August 2016

**A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE**

Our Vision

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

Our Values

We are:

Impartial: *we do not take sides*

Respectful: *we are considerate and courteous*

Inclusive: *we value diversity*

Dedicated: *we are determined and focused*

Fair: *we are honest and act with integrity*



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

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

Ms Samantha Brady-Bott died of heart failure at HMP Eastwood Park. She had only been in prison four days when she was found unresponsive in her cell. Ms Brady-Bott was 41 years old. I offer my condolences to Ms Brady-Bott's family and friends.

Ms Brady-Bott's clinical care was lacking. She had been taking medication known to affect the heart rhythm, but its impact was not monitored. The morning unlock procedures were not adequate and an emergency code was not radioed at the earliest opportunity. It is unlikely that these weaknesses changed the outcome for Ms Brady-Bott, but in other cases they might have been crucial.

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

March 2017

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Summary

Events

1. Ms Samantha Brady-Bott was sentenced to five months for theft and admitted to HMP Eastwood Park on 2 August 2016. She had been to Eastwood Park several times before.
2. Officers placed Ms Brady-Bott under suicide and self-harm prevention procedures, because she reported having recently been suicidal, and being depressed and anxious. A healthcare assistant at the reception health screen noted that Ms Brady-Bott had both drug and alcohol misuse issues. She also had mental health issues and took anti-depressant medication and quetiapine, an anti-psychotic. She smoked cigarettes and was overweight.
3. A doctor reviewed her later that day, and prescribed methadone replacement therapy for drug misuse, and librium to treat alcohol withdrawal symptoms. Both prison and healthcare staff monitored her.
4. On 6 August, an officer thought she heard Ms Brady-Bott snoring when she unlocked her cell in the morning. She did not try to wake her, or gain a positive response. Later, the officer noticed that Ms Brady-Bott had not left her cell for breakfast. The officer entered the cell, and found Ms Brady-Bott unresponsive.
5. The officer fetched another officer, they both checked Ms Brady-Bott, and radioed an emergency code. Healthcare staff attended and tried to resuscitate Ms Brady-Bott. Paramedics arrived at 9.50am and continued with resuscitation. However, it was not successful and a doctor pronounced Ms Brady-Bott dead at 10.20am.

Findings

6. The investigation found that the clinical care Ms Brady-Bott received was not equivalent to that she could have expected to receive in the community. She had been to Eastwood Park a number of times in the past few years. No one, in prison or indeed in the community, had monitored the possible effects to her heart from the medications she was taking, as should have happened.
7. Ms Brady-Bott was monitored via suicide and self-harm prevention measures. However, on the morning when she was found unresponsive in her cell, no officer tried to gain a positive response from Ms Brady-Bott, in line with prison protocol. An emergency medical code was not called at the earliest opportunity, although the delay was minimal.

Recommendations

- The Head of Healthcare should ensure that prisoners taking medications with known side effects to heart rhythms are given a six monthly ECG checks in line with community practice.

- The Governor should ensure that when a cell door is unlocked, staff satisfy themselves of the wellbeing of the prisoner and that there are no immediate issues that need attention.
- The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies, including calling an emergency code at the earliest opportunity.

The Investigation Process

8. 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.
9. The investigator obtained copies of relevant extracts from Ms Brady-Bott's prison and medical records.
10. The investigator interviewed two members of staff at Eastwood Park on 12 October.
11. NHS England commissioned a clinical reviewer to review Ms Brady-Bott's clinical care at the prison.
12. We informed HM Coroner for Avon of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
13. Ms Brady-Bott's family received a copy of the initial report. They did not raise any further issues, or comment on the factual accuracy of the report
14. The initial report was shared with the Prison Service. The Prison Service pointed out one factual inaccuracy. This report has been amended accordingly.

Background Information

HMP Eastwood Park

15. HMP Eastwood Park in South Gloucestershire opened as a female prison in March 1996, taking in prisoners from HMP Pucklechurch. The establishment opened a mother and baby unit in 2004 and the Mary Carpenter Unit (MCU) in 2005, which held 17year olds. In 2013, the prison ceased to hold 17 year olds, and the Mary Carpenter Unit became unit 10, an enhanced non-smoking unit. The Kinnon unit, a substance misuse unit opened in 2009.

HM Inspectorate of Prisons

16. The most recent inspection of HMP Eastwood Park was in November 2013. Inspectors reported that first night and early days support was now very good and much improved from the previous inspection. The support for women who were vulnerable to self-harm was good. The complex needs unit provided some excellent support to the women with the highest level of need in the population. Significant progress had been made in providing treatment and support for the high number of women with substance misuse problems.

Independent Monitoring Board

17. 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 2015, reported that the IMB comment that mental health services have seen very positive developments with the addition of new staff. Physical health issues, including substance misuse, generated the most applications to the IMB with access to timely health care and continuity of medication being the most frequently cited.

Previous deaths at HMP Eastwood Park

18. Ms Brady-Bott is the third of five prisoners to die of natural causes at Eastwood Park since January 2014. There are no significant similarities with the previous deaths.

Key Events

19. Ms Samantha Brady-Bott had been to prison several times in recent years. Most stays were short. On 2 August 2016, she was sentenced to five months imprisonment for theft. She was admitted to HMP Eastwood Park, where she had been held for her previous offences since June 2013.
20. When Ms Brady-Bott arrived in prison, officers opened an ACCT (the term used for management under Prison Service suicide and self-harm prevention procedures) because she reported trying to kill herself within the last week while in the community. She said she was depressed, anxious and having nightmares. Officers assessed her as a low risk of suicide and self-harm, and planned to monitor her twice hourly.
21. In the reception health screen, a healthcare assistant noted that Ms Brady-Bott had smoked heroin, was dependent on alcohol and had last drunk alcohol the day before. He also noted that she had mental health issues, and took fluoxetine (to treat depression) and quetiapine (an anti-psychotic). She declined smoking cessation advice. She weighed 129kg. The healthcare assistant referred her to the substance misuse service.
22. A prison GP reviewed her later that day, and prescribed methadone replacement therapy for drug misuse, and librium to treat alcohol withdrawal symptoms.
23. The next day, Ms Brady-Bott's blood pressure was recorded as normal, 98/70, (normal blood pressure is between 90/60 and 120/80). On 3 August, a nurse went to give Ms Brady-Bott her evening medication at about 10.00pm and saw through the viewing hatch that Ms Brady-Bott had something around her neck. The nurse entered the cell with officers, and removed a paper bag from around Ms Brady-Bott's neck, which she was using as a ligature. She was able to breathe and talk normally, and took her evening medication.
24. The frequency of observations of her remained the same and officers signed the document to show they had checked her at least twice an hour. These checks continued until Ms Brady-Bott's death and did not record any concerns.
25. A prison GP reviewed Ms Brady-Bott on 5 August. Ms Brady-Bott reported she felt more settled then when she entered prison.

6 August

26. An officer unlocked the cells on Ms Brady-Bott's landing on the morning of 6 August, and reported unlocking Ms Brady-Bott's cell at about 8.50am. She believed she heard Ms Brady-Bott snoring and saw her lying on her left side. The officer went to the office and signed Ms Brady-Bott's ACCT paperwork.
27. Sometime after 9.25am, the officer noticed that Ms Brady-Bott had not gone for breakfast. She went to the cell and knocked on the door, and shouted for her to get up. When there was no response, the officer went into the cell and thought that something was wrong. She went to get another officer and they went back into the cell together.

28. The officer touched Ms Brady-Bott and noticed that there was some blood and vomit on the pillow, and radioed an emergency code blue, which was recorded at 9.35am (an emergency code blue indicates a prisoner is unconscious, not breathing or is having breathing difficulties). A nurse and healthcare assistant attended quickly. They began cardiopulmonary resuscitation (CPR). Other staff attended and another healthcare assistant brought a defibrillator. It did not suggest shocking Ms Brady-Bott.
29. An ambulance arrived at 9.50am and paramedics assisted with CPR. It was unsuccessful, and a doctor pronounced Ms Brady-Bott dead at 10.20am.

Contact with Ms Brady-Bott's family

30. On 6 August, Eastwood Park requested a family liaison officer from a prison nearer to Ms Brady-Bott's family, to visit the family home and inform them that Ms Brady-Bott had died. They gave Ms Brady-Bott's parents contact details for a family liaison officer from Eastwood Park. She visited the family on 7 August and offered ongoing support.
31. The funeral was held on 23 September, and the prison contributed towards the costs, in line with national instructions.

Support for prisoners and staff

32. After Ms Brady-Bott's death, both prison and healthcare staff involved in the emergency response were debriefed to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.
33. The prison posted notices informing other prisoners of Ms Brady-Bott'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 Brady-Bott's death.

Post-mortem report

34. The post-mortem report, reported that Ms Brady-Bott had an improperly formed left coronary artery in her heart. This is associated with sudden death, as the result of an irregular heartbeat. Medication may have contributed to her death, as medications such as fluoxetine and quetiapine are known to sometimes cause heart irregularities. However, this is very rare. Quetiapine and fluoxetine can also cause hypotension, which would reduce the blood flow through the abnormal heart, and cause the heart to stop.
35. The cause of death was presumed to be an irregular heart beat caused by an abnormal left artery. Medication with known side effects to heart rhythms, also contributed.

Findings

36. The clinical reviewer concluded that the care Ms Brady-Bott received was not equivalent to the care she could have expected to receive in the community.
37. Ms Brady-Bott was prescribed quetiapine and fluoxetine, a medication known to affect the rhythm of the heart. It is standard practice for echocardiograms (ECG – to test the electrical activity of the heart) to be completed every six months. There is no evidence that Ms Brady-Bott had an ECG since 2013, in either the community or prison. At her latest reception screening, her heart rate was not checked, which could have ruled out an irregular heart rate and an ECG was not considered. The clinical reviewer said it would be expected and good practice, considering the medication she was prescribed. We make the following recommendation:

The Head of Healthcare should ensure that prisoners taking medications with known side effects to heart rhythms are given a six monthly ECG checks in line with community practice.

Unlocking cells in the morning

38. Prison officers are expected to check on a prisoner's wellbeing when unlocking cells. The Prison Officer Entry Level Training (POELT) manual states that "Prior to unlock, staff should physically check the presence of the occupants in every cell. You must ensure that you receive a positive response from them by knocking on the door and await a gesture of acknowledgement. If you fail to get a response you may need to open the cell to check. The purpose of this check is to confirm that the prisoner has not escaped, is ill or dead". Prison Service Instruction 75/2011 states that "there need to be clearly understood systems in place for staff to assure themselves of the well being of prisoners during or shortly after unlock... Where prisoners are not necessarily expected to leave their cell, staff will need to check on their well-being, for example by obtaining a response during the unlock process".
39. At unlock, the officer did not check for a response because she thought she heard snoring. Ms Brady-Bott was also expected to leave her cell shortly for breakfast. In these circumstances, the officer's decision to not gain a verbal response from Ms Brady-Bott was understandable. However, Ms Brady-Bott was also on an ACCT and, therefore, identified as vulnerable and we would have expected a conscious effort to get a verbal response.
40. There is no evidence that a more thorough check would have made a difference in the outcome for Ms Brady-Bott, but in other circumstances it might be crucial. We make the following recommendation:

The Governor should ensure that when a cell door is unlocked, staff satisfy themselves of the wellbeing of the prison and that there are no immediate issues that need attention.

Emergency response

41. Prison Service Instruction (PSI) 03/2013 requires prisons to have a medical emergency response code protocol, which should ensure that an ambulance is called automatically in a life-threatening medical emergency. The PSI explicitly states that when a medical emergency is called over the radio network, an ambulance must be called immediately and local procedures should ensure this.
42. It is clear that when the officer called an emergency code blue, to indicate a prisoner with breathing difficulties, healthcare staff responded promptly and control room staff immediately called an ambulance. However, she did not initially call a code blue, but got another member of staff to come to the cell with her. In interview, the officer stated that it would have taken a maximum of two minutes for them to return to the cell.
43. The emergency response after the emergency code was appropriate. It did not take long for medical help to arrive as the healthcare department is next to the wing where Ms Brady-Bott lived. However, in other circumstances, a delay in calling an emergency code could have been critical. We make the following recommendation:

The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies, including calling an emergency code at the earliest opportunity.

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