

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Ms Neagat Shanaz a prisoner at HMP Drake Hall on 12 July 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 we oversee can improve their work in the future.

Ms Neagat Shanaz died in hospital on 12 July 2018, after collapsing at HMP Drake Hall on 9 July. She was 47 years old. I offer my condolences to Ms Shanaz's family and friends.

An initial post-mortem report found that Ms Shanaz had died of complications arising from her diabetes. However, the cause of death was revised after a report from a hospital consultant stated that Ms Shanaz had presented at the hospital after taking a deliberate overdose of metformin (diabetes medication).

Our investigation found no evidence that Ms Shanaz had taken a metformin overdose. When police and prison staff searched Ms Shanaz's room after her death, they found full boxes of metformin and nothing to indicate that Ms Shanaz had taken an excessive amount of any of her medication.

I am satisfied that Ms Shanaz received a good standard of clinical care at Drake Hall. However, because prison staff were unaware that Ms Shanaz was diabetic, they did not alert healthcare staff when she stopped eating and drinking over the weekend of 6 to 8 July. By the time Ms Shanaz collapsed on 9 July, her blood sugar levels were dangerously low and although she was taken to hospital, she never recovered.

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

August 2019

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Summary

Events

1. On 29 November 2017, Ms Neagat Shanaz was sentenced to 28 months in prison for immigration offences. She was moved to HMP Drake Hall on 22 January 2018.
2. Ms Shanaz had several health conditions including diabetes, polycystic ovary syndrome (PCSO) and asthma. She was prescribed metformin to treat her PCSO and diabetes, which she held in her possession.
3. On 19 February, a nurse referred Ms Shanaz to the mental health team after she said she was feeling low and having difficulties sleeping. A nurse from the mental health team rejected the referral on the basis that Ms Shanaz would need to see the GP first. The nurse said she would put Ms Shanaz on the GP waiting list but she did not do this. A GP prescribed some sleeping tablets to Ms Shanaz on 21 February but he did not see her. Ms Shanaz saw healthcare staff on a further 13 occasions but made no further mention of mental health concerns.
4. On 6 July 2018, Ms Shanaz became distressed after finding out that her parents were aware she was in prison. She isolated herself in her room and stopped eating and drinking. Her friends alerted a prison officer who spoke to Ms Shanaz on 7 July. The officer made a note in Ms Shanaz's record but she did not alert healthcare or any other member of staff to check on Ms Shanaz before she went off duty.
5. On the morning of Monday 9 July, Ms Shanaz collapsed in the corridor. Staff were concerned that Ms Shanaz may have taken an illicit substance, but she said she had not taken anything. The nurse who assessed her found that her blood sugar levels were dangerously low and sent her to hospital by emergency ambulance.
6. Ms Shanaz died in hospital on 12 July. The original post-mortem report concluded that she died from diabetic ketoacidosis (dangerous build-up of ketones in the body when it cannot produce enough insulin), caused by bronchopneumonia (lung infection). However, following a report from one of the hospital doctors who treated Ms Shanaz that stated she had taken 58 metformin tablets, the post-mortem report was amended to show that she died from a metformin overdose.

Findings

7. Our investigation at the prison found no evidence that Ms Shanaz had taken a metformin overdose. When staff searched her room, they found boxes of unopened metformin but no empty packages to suggest she had taken an overdose. Despite making enquiries with the hospital, we have been unable to establish where the information that she had taken 58 metformin tablets came from.

8. We found that prison staff were not aware that Ms Shanaz was diabetic or that she had stopped eating and drinking over the weekend of 6 to 8 July, so no one contacted healthcare staff to check on her.
9. Although the officer who spoke to Ms Shanaz wrote a note in her prison record, we found no evidence that this was recorded in the wing observation book or flagged up to any other member of staff who may have had direct contact with Ms Shanaz over the weekend. We found no evidence that anyone checked on Ms Shanaz's welfare after the officer spoke to her on 7 July.
10. We found that, overall, Ms Shanaz received a good standard of clinical care. However, healthcare staff did not add her to the waiting list to see the GP about her low mood.

Recommendations

- The Governor should ensure that staff record significant information about the welfare of prisoners in the wing observation book.
- The Head of Healthcare should remind staff to ensure they follow up action to add patients to the GP waiting list as necessary.

The Investigation Process

11. The investigator issued notices to staff and prisoners at HMP Drake Hall informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
12. The investigator obtained copies of relevant extracts from Ms Shanaz's prison and medical records.
13. NHS England commissioned a clinical reviewer to review Ms Shanaz's clinical care at the prison.
14. The investigator and clinical reviewer interviewed five members of staff at HMP Drake Hall. The investigator separately interviewed three members of staff and seven prisoners. The interviews took place between July 2018 and April 2019.
15. We informed HM Coroner for Staffordshire South of the investigation. The coroner gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
16. The investigator contacted Ms Shanaz's sister to explain the investigation and to ask if the family had any matters they wanted the investigation to consider. Ms Shanaz's sister did not raise any issues.
17. Ms Shanaz's family received a copy of the initial report. They did not raise any concerns regarding factual accuracy of this report.

Background Information

HMP & YOI Drake Hall

18. HMP Drake Hall is a closed prison which holds just over 300 sentenced women. Accommodation consists of 15 house units with mainly single rooms. Each house unit has a small kitchen, a laundry room and a television lounge. There is also a 25-room open unit outside the prison perimeter. Healthcare services are provided by Care UK.

HM Inspectorate of Prisons

19. The most recent inspection of HMP & YOI Drake Hall was carried out in July 2016. Inspectors found that levels of self-harm were lower than in many other women's prisons and good care was provided to those needing support. Challenges with drug use and illicit alcohol were well managed and security arrangements were appropriate. Inspectors judged Drake Hall a respectful prison with good staff-prisoner relationships at its core. The prison had recently received the 'Enabling Environment' award from the Royal College of Psychiatrists. This is a quality mark for organisations that can demonstrate they promote good relationships and wellbeing, and Drake Hall was the first prison in England and Wales to receive the award.
20. Inspectors found that one area of major weakness at the prison was healthcare provision. There were some notable failings, namely evidence of delays in accessing many of the services and several aspects of medications management were deficient.

Independent Monitoring Board

21. 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 annual report for the year ending 31 October 2017, the IMB noted that Drake Hall provided a safe and secure environment for prisoners where they were treated with humanity and decency. High professional standards were observed by staff and there were consistently good relationships between staff and prisoners. However, the IMB were concerned about the standards of accommodation in two of the house units and also the limited availability of female GPs at the prison.

Previous deaths at HMP & YOI Drake Hall

22. Ms Shanaz was the third prisoner to die at Drake Hall since July 2016. Of the previous two deaths, one was self-inflicted and one was due to natural causes. There has been one death since, from natural causes. There are no similarities between Ms Shanaz's death and previous deaths at the prison.

In-possession medication

23. Ideally, prisoners should be responsible for managing their own medication and have the autonomy they would have in the community. There are a number of benefits to this approach, but prisons also have a duty of care to ensure security and the safety of prisoners. Allowing prisoners to keep stocks of medication in

their possession can lead to bullying and intimidation, trading in medication, an increased risk of self-harm by overdose and other misuse. The risks and benefits therefore need to be carefully assessed.

Key Events

24. On 29 November 2017, Ms Neagat Shanaz was sentenced to 28 months in prison for immigration offences. This was her first time in prison. Ms Shanaz was initially sent to HMP Bronzefield and then moved to HMP Downview on 13 December. While at Downview she requested a transfer to HMP Drake Hall so she could be nearer to her family.
25. On 22 January 2018, Ms Shanaz was moved to HMP Drake Hall. Reception staff recorded that she had no mental health problems and no history of suicide or self-harm. A nurse carried out Ms Shanaz's reception healthcare screening and noted she had Type 2 diabetes, polycystic ovary syndrome (PCOS) and asthma. Ms Shanaz told the nurse that she took metformin medication for PCOS and did not have diabetes. The nurse assessed Ms Shanaz as suitable to have her medication in possession. A prison GP prescribed Ms Shanaz's medication in line with her previous prescriptions. Ms Shanaz was located in a shared room.
26. A nurse carried out a secondary healthcare screening on Ms Shanaz on 23 January. The nurse identified no significant concerns.
27. On 30 January, Ms Shanaz had an asthma review with a nurse where she complained that mould in her room was affecting her asthma. The nurse said she would discuss this with prison staff.
28. On 5 February, a prison GP reviewed Ms Shanaz's diabetes control and recorded a satisfactory reading which was an improvement from the test she had in June 2017. The prison GP suggested a repeat test in 6-12 months.
29. On 15 February, Ms Shanaz was unable to provide a urine sample for a random mandatory drug test (MDT) and was placed on report.
30. On 19 February, Ms Shanaz told a nurse that she was feeling low, struggling to sleep and not getting on with her roommate. The nurse made a referral to the mental health team and sent a request to a prison GP to prescribe some sleeping tablets for Ms Shanaz. A nurse rejected the mental health referral, stating that Ms Shanaz would need to see the GP first. The nurse noted that she would add Ms Shanaz to the GP waiting list but she did not do this.
31. On 21 February, a prison GP prescribed Ms Shanaz with some sleeping tablets, as requested by a nurse, but he did not see her to discuss her low mood.
32. On 25 February, Ms Shanaz was moved to another room. On 11 May, she moved to a single room in a different unit.
33. On 4 June, Ms Shanaz asked a prison GP to provide her with medical evidence to support her MDT appeal. She told a prison GP that her normal habit was to pass urine only once in the morning, despite drinking a lot. The prison GP noted this in her record but he did not provide her with the evidence she required.
34. On 26 June, a nurse noted that Ms Shanaz had again asked for evidence to support her MDT appeal, stating that had been unable to produce a urine sample within five hours. She noted that Ms Shanaz had already discussed this with a prison GP and advised Ms Shanaz to speak to the healthcare manager.

35. On 4 July, Ms Shanaz had an asthma medication review with a pharmacist. Ms Shanaz told him that her asthma was under control but he noted a reduction in her lung function and that she was wheezing throughout the consultation. He advised her to use her inhaler morning and night and said he would review her again in a month.

Events of 6-8 July

36. On 6 July, Ms Shanaz attended a weight-loss gym session. Ms Shanaz had previously been attending these sessions regularly and had been steadily losing weight. A nurse noted that she had gained 4kg in two weeks but Ms Shanaz said she had not been eating. The nurse advised her to complete a diet and exercise diary over the next week and said she would devise an achievable plan for her.
37. Later that day, Ms Shanaz took part in a bike ride event at the prison. Her friend told the investigator that they all had an enjoyable time and Ms Shanaz was in good spirits. However, Ms Shanaz became distressed during the evening, telling her friends that her parents had found out she was in prison and she believed they were going to disown her. A fellow prisoner and Safer Custody representative described Ms Shanaz as hysterical and said that she told her there was no point in carrying on. Ms Shanaz went to her room and refused to speak to anyone.
38. On 7 July, some of Ms Shanaz's friends checked on her as they were concerned she was distressed and refusing food and drink. Her friend said she knocked on Ms Shanaz's door but she did not answer. The friend said she went to the Safer Custody office and told an officer that she was concerned about Ms Shanaz. The friend said she would usually have reported her concerns to a Custodial Manager (CM) but the CM was busy dealing with another prisoner.
39. The officer told the investigator that she was approached by two of the prisoner Safer Custody representatives who told her that Ms Shanaz was upset about her MDT appeal and her family finding out she was in prison. The officer said that she discussed this with the CM who told her to go and speak to Ms Shanaz.
40. The officer said she went to Ms Shanaz's room and found her to be visibly upset and crying. She said she spent some time talking to Ms Shanaz who only responded by nodding and shaking her head or with short answers. The officer asked her if she had any thoughts of harming herself and she said she did not. Ms Shanaz said she would talk to a Safer Custody representative later that evening. The officer assessed that Ms Shanaz was not at risk of suicide and self-harm and that it was not necessary to start suicide and self-harm prevention monitoring (known as ACCT).
41. The officer noted in Ms Shanaz's prison record that she had spoken to her. She wrote that Ms Shanaz assured her she was okay and she would not do anything to harm herself. The officer wrote that 'CM has been informed'. The officer told the investigator that she would have alerted healthcare if she had specific concerns that Ms Shanaz was not eating or drinking. She said she did speak to the CM before she spoke to Ms Shanaz but she did not report back to the CM or anyone else after speaking to Ms Shanaz. The officer said she thought she may also have written in the wing observation book, but we found no evidence of this.

She said she then went off duty and did not return to the prison until Tuesday 10 July.

42. We found no evidence that any member of staff checked on Ms Shanaz after the officer spoke to her on 7 July. Two prisoners said they thought a member of staff checked on Ms Shanaz on 8 July, but we found no record of this.

Events of 9-12 July

43. On 9 July at around 8.30am, a prisoner saw Ms Shanaz sitting on a chair in the corridor. She told the investigator that Ms Shanaz looked very unwell, her lips were dry and she told her that her legs were hurting. She ran back to her room to press her room bell.
44. An officer responded to the room bell. He said he tried to find out what was wrong with Ms Shanaz and asked her if she had taken anything, and she said she had not. Shortly afterwards, Ms Shanaz collapsed onto the floor and the officer immediately used his radio to call for medical assistance.
45. A nurse attended promptly and assessed Ms Shanaz. She found her blood sugar levels to be dangerously low, so she contacted the control room to call an ambulance. Paramedics arrived at approximately 9.20am and Ms Shanaz was taken to the hospital, accompanied by Officer A and Officer B.
46. Officer A told the investigator that Ms Shanaz did not say anything on the journey to the hospital. She said that when they arrived at the Accident and Emergency (A&E) department at the hospital, a doctor asked if she was diabetic and if she had taken any substances. Officer A said she did not know so she called the prison's healthcare team who confirmed that Ms Shanaz was diabetic and was prescribed metformin. Officer A said she thought the healthcare team told her that Ms Shanaz was prescribed 58 metformin tablets at a time and that she was assessed as suitable to have her medication in-possession.
47. Officer A said that a supervising officer (SO) from another prison was called in to take over from Officer B. Officer A said that she and the SO agreed that they should open an ACCT, but she could not recall what led them to believe that Ms Shanaz had taken a deliberate overdose of 58 metformin tablets, as recorded on the ACCT documentation.
48. Ms Shanaz was initially treated on the critical care unit but later sedated and transferred to another hospital for specialist treatment. She did not regain consciousness and died on Thursday 12 July.

Contact with Ms Shanaz's family

49. Ms Shanaz's sister was her nominated next of kin. The prison's family liaison officer (FLO) and the prison chaplain contacted Ms Shanaz's sister by phone on the afternoon on 9 July to tell her that Ms Shanaz was in hospital. Ms Shanaz's sister and other family members arrived at the hospital on 10 July and were with Ms Shanaz when she died. The prison contributed to the cost of Ms Shanaz's funeral, in line with Prison Service instructions.

Support for prisoners and staff

50. The Governor issued a notice to staff informing them of Ms Shanaz's death and offering support. Staff said they felt supported by managers and colleagues.
51. The Governor posted a notice for prisoners informing them of Ms Shanaz's death and offering support. Staff reviewed all prisoners assessed as at risk of suicide and self-harm, in case they had been adversely affected by Ms Shanaz's death.

Post-mortem report

52. The original post-mortem report concluded that Ms Shanaz's death was due to diabetic ketoacidosis (where the body runs out of insulin and dangerously high levels of blood acids, called ketones, build up), caused by bronchopneumonia (lung infection – infections can cause the body to produce hormones that counter the effect of insulin). The toxicologist found metformin levels above the therapeutic range but said this could be due to the way in which metformin accumulates in people with poor kidney function. The pathologist stated, "Unfortunately, the toxicology neither proves or refutes the possibility of metformin overdose".
53. Following a report by a consultant in the critical care unit at a University Hospital, which stated that Ms Shanaz was being treated for a deliberate overdose of 58 metformin tablets, the pathologist amended the cause of death to bronchopneumonia, caused by severe metabolic acidosis (when the body produces too much acid or the kidneys are not removing enough acid from the body) and metformin toxicity.

Findings

Ms Shanaz's cause of death

54. The original post-mortem report showed that Ms Shanaz died from diabetic ketoacidosis, caused by bronchopneumonia. The pathologist noted that Ms Shanaz was thought to have taken a metformin overdose when she was transferred to a University Hospital and that toxicological analysis showed a metformin level at above therapeutic range. However, the pathologist noted the toxicologist's comments about metformin accumulation in those with renal impairment (poor kidney function). The pathologist concluded that Ms Shanaz "died from overwhelming lung sepsis possibly due to a staphylococcus against a background of poorly controlled diabetes mellitus", and said, "I can find no positive evidence at autopsy or from the information presented to me at the time of autopsy to suggest deceased died in anyway other than by natural causes."
55. Subsequently, HM Coroner for South Staffordshire was provided with a report by a hospital consultant who treated Ms Shanaz at the University Hospital. The consultant said Ms Shanaz had "presented to the Emergency Department with a deliberate overdose of a fatal dose of metformin (58 tablets)". The Coroner issued a revised cause of death, which said Ms Shanaz died from bronchopneumonia, caused by severe metabolic acidosis and metformin toxicity.
56. Our investigation found no evidence that Ms Shanaz had taken a deliberate overdose of metformin. When staff searched her room, they found unopened boxes of metformin and there was no evidence of empty packaging to show that she had taken an excessive amount of metformin or any other drug. At the time of her collapse, Ms Shanaz told an officer that she had not taken anything and we found no evidence that she told anyone at any other time that she had taken an overdose.
57. An officer said she was asked by a hospital doctor if Ms Shanaz was diabetic and if she could have taken anything so she checked with the prison healthcare department. The officer then confirmed to the hospital doctor that Ms Shanaz was diabetic. She also thought she had been told that Ms Shanaz was prescribed metformin in boxes of 58 tablets. She could not recall what had led her and a SO to start ACCT procedures on the basis that Ms Shanaz had taken a deliberate overdose of metformin.
58. We have been unable to establish where the consultant's statement in his report that Ms Shanaz took a deliberate overdose of 58 metformin tablets came from. It is possible that there was some miscommunication that led doctors to believe that Ms Shanaz had taken a deliberate overdose when they were told about her in-possession medication. During our investigation, including interviews with prison and healthcare staff, we found no evidence that Ms Shanaz took a deliberate overdose of metformin.

Weekend of 6 to 8 July

59. Ms Shanaz was distressed over the weekend of 6 to 8 July to the point that she was isolating herself and refusing to eat or drink. We found that the ongoing issue of her failed MDT was causing her distress and she was worried that this

might affect her early release. Additionally, she had just discovered that her parents had found out that she was in prison and she believed they were going to disown her.

60. An officer spoke to Ms Shanaz on the evening of Saturday 7 July and noted that she said she was okay and would not do anything to harm herself. The officer said she did not think it was necessary to start ACCT procedures and she based this on the fact that Ms Shanaz did not have a history of self-harm. A CM said she was led to believe that the matter was not serious enough to warrant starting ACCT procedures. Two prisoners mentioned that another officer checked on Ms Shanaz on Sunday 8 July, but we found no evidence of this.
61. We accept that, for reasons of medical confidentiality, staff would not have known that Ms Shanaz was diabetic and therefore did not recognise the potential risk when other prisoners said they thought she was not eating or drinking. We consider that, had they been aware of the risks, staff would have informed healthcare.
62. In the event, we found that staff did not consider Ms Shanaz's physical health to be at imminent risk and they also did not consider her to be at risk of suicide or self-harm. From the evidence available to us, we are satisfied that this was a reasonable assessment.
63. However, although an officer put an entry in Ms Shanaz prison record before she went off duty, we are concerned that this was not immediately obvious to other staff who would have been responsible for Ms Shanaz's welfare over the weekend. We would have expected to see an entry in the wing observation book to make staff aware of Ms Shanaz's distress so that they could take appropriate action to check on her and support her further, if necessary. We therefore make the following recommendation:

The Governor should ensure that staff record significant information about the welfare of prisoners in the wing observation book.

Clinical care

64. The clinical reviewer concluded that Ms Shanaz received a standard of care at least equivalent to that which she could have expected to receive in the community. She found that Ms Shanaz's health needs were assessed and reviewed in a timely manner. However, she noted one occasion when Ms Shanaz was not added to the GP waiting list to discuss her low mood. We make the following recommendation:

The Head of Healthcare should remind staff to follow up action to add patients to the GP waiting list as necessary.

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