Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Ms Lorraine Green a prisoner at HMP Low Newton on 7 January 2019

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.

The Ombudsman's 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 Lorraine Green died of chronic liver disease caused by alcohol-related cirrhosis of the liver on 7 January 2019 while a prisoner at HMP Low Newton. She was 52 years old. I offer my condolences to Ms Green's family and friends.

Ms Green had a number of pre-existing medical conditions, complicated by a long history of both alcohol and drug misuse. Although she informed staff of this, she did not tell them that she had previously been diagnosed with hepatitis C, for which she had declined all treatment.

I am satisfied that when healthcare staff were made aware of Ms Green's conditions, she received a good standard of care, equivalent to that which she could have expected to receive in the community.

I am concerned, however, that decisions to use restraints on Ms Green during her final admission to hospital on 2 January 2019, were clearly unjustified and did not take account of her serious ill-health. As a result, she was still restrained when she had a fatal cardiac arrest.

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**

Contents

Summary

Events

1. On 14 May 2018, Ms Lorraine Green was remanded to HMP New Hall after being charged with robbery.

2. Ms Green arrived into prison custody with a number of pre-existing medical conditions, for which she received prescribed medication. Her medical history was complicated by a long history of substance misuse. Ms Green was referred to both the drug treatment and mental health teams at the prison.

3. On 15 October, Ms Green was noted to be slurring her words and appeared generally unwell. She was taken to hospital for review. Hospital staff carried out a number of tests which showed she had hepatitis C. Ms Green discharged herself from hospital before any further tests could be completed.

4. Ms Green refused to attend any follow up appointments offered to her, despite healthcare staff encouraging her to do so. It was later established that she had been diagnosed with hepatitis C in 2006, but she had failed to disclose her diagnosis to healthcare staff.

5. On 30 October, Ms Green was transferred to HMP Low Newton.

6. On 16 November, Ms Green complained of tremors and confusion. She was admitted to hospital by emergency ambulance for further review. Hospital staff diagnosed Ms Green with pancytopenia (reduced levels of all three types of blood cells). They admitted her as an inpatient to treat her symptoms and explore her conditions further, but before they could do so Ms Green discharged herself against medical advice.

7. On 30 November, a prison GP reviewed Ms Green and considered she was dehydrated and appeared to be in a weakened state. He sent her to hospital by emergency ambulance for review. Hospital staff diagnosed Ms Green with encephalopathy (changes in the brain caused by liver disease) and decompensated liver disease (scarring caused by cirrhosis). She received a course of intravenous antibiotics and on 13 December, she was discharged from hospital and was sent to the inpatient unit at Low Newton.

8. During a routine review on 2 January 2019, Ms Green reported pain and swelling in her abdomen. A prison GP sent Ms Green to hospital by emergency ambulance for further review. Hospital staff drained the fluid from her abdomen and referred her to the gastroenterology team. Ms Green remained in hospital as an inpatient.

9. On 5 January, hospital staff considered Ms Green's condition had stabilised to the extent she could be discharged from hospital and return to prison. However, shortly before that could take place, she became short of breath and had a raised temperature. Hospital staff decided Ms Green should stay in hospital.

10. Ms Green's condition continued to deteriorate and on 7 January, at 1.00pm, she had a cardiac arrest. At 1.50pm, it was confirmed that Ms Green had died.

11. The coroner gave Ms Green's cause of death as decompensated hepatic failure (chronic liver disease, commonly the result of hepatitis) with bowel obstruction and cirrhosis due to alcohol-related liver disease.

Findings

12. We are satisfied that the standard of clinical care Ms Green received at Low Newton was equivalent to that which she could have expected to receive in the community. Healthcare staff appropriately assessed her clinical needs, and made timely referrals to hospital where necessary.

13. We are concerned, however, that following Ms Green's final admission to hospital on 2 January 2019, her level of risk, and the level of restraint used, was not appropriately reviewed. We do not consider it was appropriate or proportionate to use restraints, given Ms Green's very poor and deteriorating health.

Recommendations

- The Governor should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position, and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.

- The Governor and Head of Healthcare should ensure that any staff named in this report are given the opportunity to read the report at the draft stage in line with paragraph 1.11 of PSI 58/2010.

The Investigation Process

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

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

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

17. We informed HM Coroner for Durham and Darlington of the investigation. The coroner gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

18. Ms Green's family received a copy of the initial report. They raised a number of issues that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

19. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Background Information

HMP Low Newton

15. HMP Low Newton, near Durham, holds up to 329 women. The population includes women on remand, prisoners serving short and long sentences, and some high security prisoners. Healthcare services at the prison are provided by Care UK.

HM Inspectorate of Prisons

16. The most recent inspection of HMP Low Newton was in February 2018. Inspectors noted that overall, the healthcare provision at the prison was of a good standard and delivered by a skilled group of staff.

17. Inspectors also noted that there were clinics in place specifically for women's health and for those prisoners with long-term health issues. However, they were concerned the location of primary care facilities and the inpatient unit was unsatisfactory.

Independent Monitoring Board

18. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help ensure that prisoners are treated fairly and decently. In its most recently published report for the year to 28 February 2017, the IMB noted that there were good systems in place for those prisoners arriving into custody. Women were given a full medical screening to identify any health issues and then, if required, appropriately referred to one of the specialist clinics available at the prison.

19. The IMB noted there was a clear pathway, which included detoxification and counselling, for those prisoners arriving into custody with a history of substance misuse.

Previous deaths at HMP Low Newton

20. Ms Green was the second prisoner to die at HMP Low Newton since February 2016. The previous death was self-inflicted. There are no similarities between the two deaths.

Key Events

HMP New Hall

21. On 14 May 2018, Ms Lorraine Green was remanded to HMP New Hall after being charged with robbery. (She subsequently received a sentence of 45 months.)

22. Ms Green had a number of pre-existing medical conditions including asthma, arthritis and an over-active thyroid.

23. On her arrival at New Hall, healthcare staff reviewed and updated Ms Green's prescribed medications and her inhaler technique was checked in line with NICE (National Institute for Health and Care Excellence) guidelines. Ms Green reported ongoing pain in a small leg wound she had developed following a previous surgical procedure. Careplans were created to manage her conditions and referrals made to specialist clinics at the prison.

24. Ms Green told healthcare staff that she had a long history of alcohol misuse, drinking approximately six litres of cider and four cans of strong lager per day. She also said that she had previously used heroin and crack cocaine, but not since 2016.

25. Prior to her arrival at New Hall, Ms Green had undertaken a supervised alcohol detoxification program and had a prescription for librium (which is used to lessen the symptoms of alcohol withdrawal) and 20mg of methadone (which is used for drug detoxification). She was also noted as being a smoker, but she refused cessation advice. Despite healthcare advice, Ms Green also declined screening for hepatitis C and B, HIV and sexually transmitted diseases.

26. Following her review, Ms Green was referred to the mental health in-reach team (MHIRT) and the integrated drug treatment service (IDTS). Her prescriptions for methadone and librium were reviewed and updated.

27. On 7 June, Ms Green was reviewed by a nurse, a member of the MHIRT. Ms Green told the nurse she had no thoughts of self-harm but did feel depressed at being in prison. She also said that her community prescription for diazepam (which is used to treat anxiety and the symptoms of alcohol withdrawal) and zoplicone (a sleeping tablet) would help her adjust to being in custody. The nurse decided that given the highly addictive nature of those drugs and Ms Green's history of substance misuse, mirtazapine would be a more appropriate anti-depressant to prescribe.

28. On 30 August, a nurse reviewed Ms Green after she complained of a tightness in her chest and a shortness of breath. Her observations (which are measurements of temperature, respiratory rate, pulse, blood pressure and blood oxygen saturation, an indicator of a patient's state of health) were taken and showed she had a low blood oxygen level and raised heart rate. A clinical practitioner later diagnosed pyoderma (a skin condition resulting in large open ulcers) and prescribed antibiotics. A careplan was created to monitor Ms Green's condition and to change her dressings regularly.

29. Later the same day, a substance misuse nurse reviewed Ms Green. Ms Green said that she wanted to reduce her prescribed level of methadone with a view to completely stopping her prescription in due course. The nurse told her a plan for complete withdrawal would be put in place but detoxification would be carried out over an extended period. Due to her lifestyle prior to being sent to prison, Ms Green was again offered screening for hepatitis C and B, HIV and sexually transmitted diseases, but she declined.

30. On 19 September, Ms Green told a nurse that in the previous three days she had vomited 'coffee grounds' (congealed blood in the stomach which when vomited has the appearance of coffee grounds) twice. The nurse noted Ms Green had undergone a laparotomy (a surgical procedure on the stomach) in 1983 to treat two ulcers and considered she might have a reoccurrence of the condition. She asked for some blood tests to be done and referred Ms Green to a prison GP for review. Despite encouragement by healthcare staff, Ms Green failed to attend the appointments to have her blood tested on two occasions.

31. On 21 September, Ms Green was reviewed by a prison GP. Ms Green said that she had not experienced any further vomiting. The prison GP examined her abdomen and noted she did not report any pain. However, he did find that her left leg appeared significantly swollen compared to the right. He referred her for a venography (radiography of a vein) to check for a possible blood the prison GP also decided that it would not be appropriate to prescribe her the drugs she was asking for.

32. On 10 October, a prison GP reviewed Ms Green. She examined her stomach and noted some swelling. Given her history of alcohol misuse, the prison GP was concerned Ms Green might have developed an enlarged liver and advised her that blood tests would be needed to help her to give a definitive diagnosis. She made an appointment for blood tests to be taken, including a screening for hepatitis C, and encouraged Ms Green to attend. The prison GP also noted the swelling in Ms Green's left leg and the prison GP's previous referral for a venography.

33. Ms Green told the prison GP that she was unhappy with the medications she was prescribed at New Hall and wanted to have her prescription reviewed. The prison GP told Ms Green that it would not be appropriate to prescribe her the medications she wanted due to their addictive nature and her ongoing substance misuse treatments. She assured Ms Green that the medications prescribed in their place would be just as effective. She planned a further review in two weeks' time.

34. On 15 October, a nurse reviewed Ms Green after prison officers reported their concern that she was slurring her words and appeared generally unwell. The nurse sent Ms Green to a hospital by emergency ambulance to be reviewed. Hospital staff completed observations and found Ms Green had a raised heart rate. They carried out a series of blood tests to try to establish the cause of her symptoms. She also underwent a scan to try to establish the cause of the swelling to her left leg. Further tests were planned but Ms Green discharged herself from hospital against medical advice.

35. On 19 October, a prison GP carried out a follow up review. He noted the blood tests carried out at the hospital showed that Ms Green had thyrotoxicosis (an over-active thyroid gland) and hepatitis C. He considered that her conditions could have been diagnosed earlier if Ms Green had not refused to have the blood tests healthcare staff had requested.

36. The same day, the prison GP discussed Ms Green's condition with hospital staff, who advised him to prescribe 20mg of carbimazole (which is used to reduce the amount of thyroid hormone produced by the thyroid gland). He reviewed her prescribed medications and referred Ms Green to the endocrinology department at a hospital for further review. He planned to carry out repeat blood tests in a further eight weeks to monitor her condition. Ms Green's careplans were updated to reflect the diagnosis of hepatitis C.

37. On 26 October, a prison GP reviewed Ms Green. She noted that hospital staff concluded that the swelling in her leg was not caused by a blood clot and therefore, the referral for a venography was no longer necessary.

HMP Low Newton

38. On 30 October, Ms Green was transferred to HMP Low Newton. Prior to her departure, a nurse reviewed Ms Green's medical notes and decided she did not have any medical conditions preventing her from being transferred.

39. During her initial healthscreen at Low Newton, Ms Green was noted as being a smoker and was issued with a Vape (a substitute for smoking). Her medical conditions were noted and prescriptions reviewed, and her careplans were updated and reviewed.

40. On 7 November, a prison GP reviewed Ms Green. He increased her prescription for carbimazole from 20mg to 30mg daily. He planned to check her thyroid function in four weeks' time, and her vitamin D level in a further ten weeks. He contacted the hospital and informed hospital staff that Ms Green had been transferred to Low Newton to ensure continuity for her referral to endocrinology.

41. On 16 November, a nurse reviewed Ms Green after she complained of experiencing tremors in her arms. She also told the nurse she had been experiencing bouts of confusion. He took her observations and referred her to a prison GP, for review. The prison GP suspected Ms Green might have developed sepsis (a life-threatening condition that arises when the body's response to infection causes injury to its own tissues and organs) and sent her to the hospital by emergency ambulance for further review.

42. Hospital staff diagnosed Ms Green with pancytopenia (reduced levels of all three types of blood cells) which they considered could be a side effect from her prescription for carbimazole. As a result, her prescription medication was altered from carbimazole to flurothiouracil, to lessen any possible side effects. They also found that she had a slight heart murmur. They admitted Ms Green to hospital as an inpatient to treat her symptoms and explore her conditions further.

43. On 18 November, Ms Green discharged herself from hospital against medical advice. When she arrived at Low Newton, she refused to be admitted to the prison's inpatient unit and signed a disclaimer to that effect.

44. On 22 November, Ms Green was reviewed by a nurse, a member the MHIRT team at the prison, to discuss her self-discharge from hospital and subsequent refusal to be admitted to the inpatient unit. She noted Ms Green was responsive to her questions and understood what was being asked of her. The nurse concluded that Ms Green had the capacity to make decisions about her treatment.

45. On 26 November, Ms Green failed to attend a review by the prison's sexual health clinic which had been scheduled as a follow up appointment to her diagnosis of hepatitis C. Despite encouragement by healthcare staff, Ms Green failed to attend several follow up appointments for her conditions.

46. The following day, a nurse reviewed Ms Green after prison officers noted her speech was again slurred and she was experiencing tremors. He took her observations but found nothing of concern. He referred her for a review by a GP.

47. On 30 November, a prison GP reviewed Ms Green. He considered she presented as dehydrated, in a weakened state and confused. He also noted she appeared to be shaking more than usual. He arranged for her to be taken to hospital by emergency ambulance for review. Hospital staff decided that Ms Green should stay in hospital as an inpatient to allow her symptoms to be explored further. Healthcare staff kept in daily contact with hospital staff, obtaining updates on her condition.

48. Hospital staff diagnosed Ms Green with encephalopathy (changes in the brain caused by liver disease) and decompensated liver disease (scarring caused by cirrhosis). She was given a course of intravenous antibiotics. Ms Green remained in hospital as an inpatient until 13 December, when she was discharged and sent to the inpatient unit at Low Newton.

49. Healthcare staff reviewed Ms Green daily. Her careplans were updated to reflect the change in her conditions, which included the daily measuring of her abdomen to monitor the progress of ascites (a build-up of fluid in the abdomen caused by liver disease).

50. On 2 January 2019, a nurse reviewed Ms Green. She told him she was experiencing increased pain and swelling in her abdomen. He weighed Ms Green and noted she had gained weight, he also noted her abdomen had increased in size. He referred her for a GP review.

51. A prison GP reviewed Ms Green later the same day. He noted she appeared to be experiencing shortness of breath and had an increase in the swelling in her abdomen, which was hard to the touch. He arranged for her to be taken to hospital by emergency ambulance for review. Ms Green was accompanied by two prison officers and was restrained using single handcuffs (one handcuff attached to the prisoner the other attached to a prison officer).

52. Hospital staff drained the fluid from Ms Green's abdomen and referred her for a review by the gastroenterology team. She remained in hospital as an inpatient, accompanied by two prison officers and restrained at all times by either single handcuffs or an escort chain (a length of chain with a handcuff at each end one attached to the prisoner and the other to a prison officer).

53. Healthcare staff regularly visited Ms Green in hospital and noted she appeared to be in good spirits, and fully understood the plan for her care while in hospital. They stayed in daily contact staff at the hospital and kept updated with her condition.

54. On 5 January, hospital staff considered that Ms Green's condition had stabilised to the extent that she could be discharged back to prison. However, shortly before her transfer, Ms Green became short of breath and had a raised temperature. Hospital staff decided she should remain in hospital as an inpatient.

55. Ms Green's condition continued to deteriorate and on 7 January, at 1.00pm, she had a cardiac arrest. Hospital staff's attempts at CPR (cardiopulmonary resuscitation) were unsuccessful, and at 1.50pm, it was confirmed that Ms Green had died.

Post-mortem report

56. The post-mortem report gave the cause of death as decompensated hepatic failure (chronic liver disease commonly the result of hepatitis) with bowel obstruction and cirrhosis due to alcohol-related liver disease.

Contact with Ms Green's Family

57. On 4 December 2018, the prison appointed an officer and a chaplain to act as family liaison officers (FLO).

58. The chaplain telephoned Ms Green's mother, who was listed as her next of kin, and informed her of her daughter's admission to hospital. He remained in regular contact with her, updating her on Ms Green's condition. He also visited Ms Green while she was in hospital on several occasions.

59. After Ms Green's death, a FLO asked a FLO from HMP Hull, a prison much closer to Ms Green's family, to visit them and break the news of her death.

60. At 3.30pm, the FLO from HMP Hull, accompanied by a Senior Officer arrived at Green's mother home address to inform her of her daughter's death.

61. Ms Green's mother was visibly upset and said that her son, Ms Green's brother, had also died recently. The FLO from HMP Hull offered the family support and explained that the FLO from HMP Low Newton would visit them the following day. He also assured the family that the prison would offer to contribute towards the cost of the funeral.

62. At 12.00pm, the following day, both FLOs from HMP Low Newton, visited Ms Green's mother at her home address. They spent time with the family offering their support and answered any questions they had about Ms Green's death.

63. Both FLOs continued to offer the family support. They visited them at their home again on 17 January to return Ms Green's property.

64. Ms Green's funeral was held on 30 January. Representatives of the prison attended the funeral. In line with national guidance, the prison offered a financial contribution to Ms Green's funeral.

Support for prisoners and staff

65. After Ms Green's death, a prison manager debriefed the staff who were accompanying her at the hospital when she died, giving them the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

66. The prison posted notices informing other prisoners of Ms Green'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 Green's death.

Findings

Clinical care

67. The clinical reviewer found that, although Ms Green had disclosed information about her pre-existing medical conditions and history of substance misuse during her initial health screens, she did not inform healthcare staff that she had tested positive for hepatitis C in 2006. Neither did she inform them that following that diagnosis, she had been offered three follow up appointments in specialist clinics, and that she had failed to attend on each occasion. (If left untreated, hepatitis C can result in liver failure.)

68. There is good evidence in Ms Green's medical records to demonstrate that following her arrival at both New Hall and Low Newton, healthcare staff repeatedly offered her screening and blood testing for a number of conditions, including hepatitis. However, despite repeated encouragement from healthcare staff, Ms Green consistently declined.

69. We are satisfied that Ms Green received appropriate care for the conditions she informed healthcare staff of. She was monitored closely and there is good evidence that comprehensive careplans were put in place to manage her care.

70. It was not until 15 October, while she was an inpatient in hospital, that that healthcare staff became aware of her previous diagnosis of hepatitis C. However, Ms Green failed to attend any follow up appointments offered to her, despite repeated advice from healthcare staff to do so.

71. The clinical reviewer concluded that the clinical care Ms Green received while at Low Newton was equivalent to that which she could have expected to receive in the community. We agree.

72. The clinical reviewer has made a recommendation about the need for face to face reviews when assessing the fitness of prisoners to transfer between establishments, which we do not repeat in this report but which the Head of Healthcare at New Hall will wish to address.

Restraints, security and escorts

73. When prisoners must travel outside the prison, a risk assessment determines the nature and level of security arrangements, including restraints. The Prison Service has a duty to protect the public, but this must be balanced with a responsibility to treat prisoners with humanity. Any restraints used should be necessary and decisions should be based on the security risk considering factors such as the prisoner's health and mobility.

74. The risk assessment for Ms Green's final admission to hospital on 2 January 2019 was signed by the Head of Residence at Low Newton. He considered Ms Green to be a medium risk to the public, and medium risk of escape. Two officers accompanied Ms Green and she was restrained using a single handcuff while on route to the hospital.

75. The risk assessment was reviewed the following day by the Head of Security at Low Newton.

76. public, but all other risk levels, including that of escape, had reduced to low. In addition, the comments box on the risk assessment noted Ms Green was physically frail due to her medical condition.

77. However, despite those changes to her level of risk and physical condition, the level of restraint was not reduced. As previously, two officers accompanied Ms Green and she was restrained using a single handcuff, or an escort chain when in bed. She remained restrained until she had a fatal cardiac arrest at 12.55pm on 7 January.

78. Public protection is critical, but security measures must be proportionate to a prisoner's individual circumstances. We are concerned that prison staff decided that it would be appropriate to use a handcuff or escort chain to restrain Ms Green given her physical condition. It is difficult to see how the assessment concluded that a woman deemed to be frail had the ability to escape unaided from two escort officers.

79. The Prison Service has a responsibility to protect the public, but security must be balanced with humanity and measures must be proportionate to a prisoner's individual circumstances. We are not satisfied that managers appropriately considered Ms Green's physical condition at the time and how this affected her risk. We make the following recommendation:

The Governor should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position, and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.

80. We consider it important that the findings of our investigations are shared with the staff involved. We, therefore, recommend:

The Governor and Head of Healthcare should ensure that any staff named in this report are given the opportunity to read the report at the draft stage in line with paragraph 1.11 of PSI 58/2010.

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