

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Ms Sarah Jaconelli, a prisoner at HMP Bronzefield, on 15 June 2017

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 Sarah Jaconelli died of hypertensive heart disease on 15 June 2017 at HMP Bronzefield. She was 55 years old. I offer my condolences to Ms Jaconelli's family and friends.

Ms Jaconelli had only been in prison for 10 days when she died. She had a complex medical history and was not always compliant with medical advice and taking medication. I am concerned that, given her serious health problems, she did not receive a secondary health screen and that the reasons for her non-attendance at appointments were not recorded or followed up.

I am also concerned that due to a lack of appropriate equipment, a nurse was unable to monitor Ms Jaconelli's blood pressure when she became unwell a few days before her death; and that no arrangements were made to monitor her condition while she was waiting to be readmitted to the healthcare inpatient unit on the day that she died.

It is disappointing that the first three staff at the cell did not start resuscitation when Ms Jaconelli was found unresponsive, although this does not seem to have affected the outcome.

However, in spite of the shortcomings identified, we agree with the clinical reviewer that, overall, Ms Jaconelli's clinical care was equivalent to that she could have expected to receive in the community.

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

March 2020

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Summary

Events

1. On 5 June 2017, Ms Sarah Jaconelli was sentenced to 18 months in prison for fraud and sent to HMP Bronzefield. It was her first time in prison.
2. Ms Jaconelli had been diagnosed with several chronic medical conditions, including diabetes, high blood pressure, asthma, angina, high cholesterol, lung disease, mini stroke, morbid obesity and mental health problems. She also had a history of self-harm and suicidal thoughts. Prison reception staff began suicide and self-harm prevention procedures (known as ACCT) and Ms Jaconelli was managed under these provisions until her death.
3. After the reception procedures, Ms Jaconelli was admitted to the inpatient unit for observation and her blood pressure was taken daily. She was discharged to a houseblock on 8 June. In prison, as in the community, Ms Jaconelli did not always cooperate with medical advice. She missed medical appointments and initially did not take her medication while fasting for Ramadan. On 8 June, a prison GP altered Ms Jaconelli's prescription, so she could take her medication at night once she had broken her fast.
4. On 11 June, Ms Jaconelli felt unwell. On 12 June, a nurse examined her after she had fainted in her cell. The nurse tried to take Ms Jaconelli's blood pressure three times, but the cuff for the monitor did not fit.
5. On 13 June, Ms Jaconelli mentioned being in pain. The next day, she did not attend a nurse triage clinic appointment.
6. At 2.30pm on 15 June, one of the operational staff asked a nurse to examine Ms Jaconelli, as she appeared unwell and drowsy. Healthcare staff arranged for her to be readmitted to the inpatient unit, but no beds were available at that time. At around 5.15pm, two prison officers found Ms Jaconelli unresponsive in her cell. Resuscitation attempts were unsuccessful and a paramedic confirmed her death at 6.35pm.

Findings

7. Overall, Ms Jaconelli's clinical care was equivalent to that which she could have expected in the community. However, the investigation revealed some deficiencies.
8. Ms Jaconelli had health assessments with a nurse and a prison GP within her first two days in prison, but she did not have the required secondary health screen. This should be offered to all prisoners and is particularly desirable for those with potentially serious medical conditions.
9. Ms Jaconelli had been diagnosed with high blood pressure and most of her initial readings showed her blood pressure was raised. There was no routine monitoring of her blood pressure after she was discharged from the inpatient unit. A nurse unsuccessfully tried to take a blood pressure reading on 12 June when

she was reported unwell, but the cuff attached to the monitor was not large enough.

10. After Ms Jaconelli was discharged from the inpatient unit, she missed several medical appointments. There is no record of the reasons, or any attempts to follow up or rebook the appointments. The healthcare department sometimes pursue this informally through wing staff, but the prison has no written policy on dealing with non-attendance for medical appointments.
11. Although healthcare staff had arranged to admit Ms Jaconelli to the inpatient unit for observation a few hours before her death, they made no arrangements to monitor her while she was waiting for a bed to become available.
12. The first three operational staff at the incident, two officers and a supervising officer, did not attempt resuscitation. Although this does not appear to have affected the outcome for Ms Jaconelli, staff should understand the need to start resuscitation quickly, unless clear signs of death are evident.
13. In spite of the code blue emergency call, a defibrillator was not automatically taken to the emergency. A nurse requested one just after starting resuscitation. Since Ms Jaconelli's death, the prison has reviewed the emergency procedures and issued guidance reminding staff where the defibrillators are located in the prison and giving explicit instructions for officers to take a defibrillator to every emergency.

Recommendations

- The Head of Healthcare should ensure that all new prisoners are offered a secondary health screen.
- The Head of Healthcare should ensure that prisoners with high blood pressure are monitored appropriately in line with NICE guidelines, and that monitoring equipment is available in the full range of sizes.
- The Head of Healthcare should ensure that when prisoners with potentially serious medical problems miss medical appointments, the reasons for non-attendance are recorded and the appointment is rebooked, if necessary.
- The Head of Healthcare should ensure that prisoners waiting to be admitted to the inpatient unit have an interim care plan and are adequately monitored.
- The Director should ensure that operational staff are aware of the importance of starting cardiopulmonary resuscitation at the earliest opportunity when a prisoner is unresponsive; and that staff first on the scene provide basic life support until health professionals arrive, unless there are clear signs of death.

The Investigation Process

14. The investigator issued notices to staff and prisoners at HMP Bronzefield informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
15. The investigator obtained copies of relevant extracts from Ms Jaconelli's prison and medical records.
16. NHS England commissioned a clinical reviewer to review Ms Jaconelli's clinical care at the prison.
17. The investigator and clinical reviewer jointly interviewed two members of staff at Bronzefield on 22 August. The investigator interviewed a further four staff at the prison on 4 September 2017 and one staff member by telephone on 21 September 2017.
18. Our investigation was suspended between 3 October 2017 and 27 November 2019, while waiting for the cause of death and, subsequently, due to the unavailability of the initial clinical reviewer. Regrettably, this delayed the initial report.
19. On 7 October 2019, the review of Ms Jaconelli's clinical care was reassigned to another clinical reviewer.
20. We informed HM Coroner for Surrey of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
21. The investigator wrote to Ms Jaconelli's next of kin, a friend, to explain the investigation and to ask if she had any matters for the investigation to consider. She did not respond to our letter.
22. The initial report was shared with HM Prison and Probation Service (HMPPS). They found three inaccuracies, which have been amended. They accepted our recommendations.

Background Information

HMP Bronzefield

23. HMP Bronzefield is a privately managed local prison in Surrey, which holds up to 557 women. It is run by Sodexo Justice Services Ltd. Sodexo provides 24-hour primary nursing care across the prison and inpatient care for up to 18 women in a dedicated unit. GP services are provided by a private company, Cimarron UK.

HM Inspectorate of Prisons

24. The most recent inspection of HMP Bronzefield was in November and December 2018. Inspectors reported that the prison was “an excellent institution” that was overwhelmingly safe for most prisoners. Healthcare services were integrated with the rest of the prison, with an appropriate range of primary care services and reasonable waiting times. Triage drop-in sessions were held on each houseblock and nurses held other clinics. Long-term medical conditions were well-managed with care plans.

Independent Monitoring Board

25. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to July 2019, the IMB reported that waiting times for healthcare services were consistent with those in the community. The number of missed appointments was high, with around 20% of appointments not attended. The inpatient unit was well-managed. However, the Board noted that the beds were often used for operational, rather than healthcare reasons, to accommodate complex prisoners who could not be managed in the houseblocks or the separation and care unit.

Previous deaths at HMP Bronzefield

26. Two prisoners died at Bronzefield in the two years before Ms Jaconelli’s death. One was a self-inflicted death and the other involved initial detoxification from illicit drug misuse in the community. Two prisoners have died from natural causes since her death. There were no similarities between Ms Jaconelli’s death and those we have already investigated.

Key Events

27. On 9 May 2017, Ms Sarah Jaconelli was convicted of fraud. On 5 June 2017, she was sentenced to 18 months in prison and taken to HMP Bronzefield. It was Ms Jaconelli's first time in prison.
28. During her reception interview, Ms Jaconelli told an officer that she had self-harmed for around ten years, most recently two days before, and that she sometimes had suicidal thoughts. She said that she had been diagnosed with post-traumatic stress disorder (PTSD) as a result of domestic abuse and used self-harm as a coping mechanism. Staff began ACCT procedures (the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm) and passed the information to the reception nurse.
29. A nurse carried out a reception health screen. Ms Jaconelli reported several physical and mental health problems, including Type 2 diabetes, hypertension (high blood pressure), asthma, heart problems, a recent mini stroke and investigations for womb, bowel and kidney cancer. She had outstanding medical appointments and was under the care of her community mental health team. Ms Jaconelli repeated the information about her history of self-harm and said she was dyslexic. The nurse referred her to the prison GP and the mental health team. She noted that Ms Jaconelli was not fit for normal location or work and arranged for her to be admitted to the prison's inpatient unit for monitoring and observation. Ms Jaconelli's blood pressure was 176/87mmHg (a normal reading is 120/80).
30. Ms Jaconelli was an Irish Traveller who had converted to Islam five weeks before she went to prison. Staff gave her a prayer mat and a copy of the Qu'ran and arranged for her to receive a special menu. It was Ramadan and she was fasting. Entries in the prison and medical records show that over the next two days Ms Jaconelli settled and slept well and completed the induction procedures.
31. On the morning of 6 June, the prison received a fax from Ms Jaconelli's community GP. In addition to the medical conditions previously reported, the fax noted unstable angina, acute coronary syndrome, morbid obesity, chronic obstructive pulmonary disease (a group of lung conditions that cause breathing difficulties), depression and hypercholesterolaemia (high cholesterol). Ms Jaconelli's cardiologist had discharged her as she had failed to attend several appointments.
32. In the afternoon, a prison GP reviewed Ms Jaconelli. He stopped her mirtazapine (antidepressant) prescription, advised her to lose weight and noted he would consider an alternative antidepressant, as weight gain was a side effect of mirtazapine. (The community GP notes had yet to be filed in the records, so he did not see them.) Ms Jaconelli's blood pressure was 184/112mmHg.
33. Later that day, Ms Jaconelli told a nurse that she was fasting for Ramadan and only took her medication once she had broken her fast. On 7 June, the nurse noted that Ms Jaconelli had not taken her medication during the day as she was fasting. She advised her of the risks of not taking her medication given her medical problems, but Ms Jaconelli insisted on fasting. Later, another nurse recorded a blood pressure of 187/113mmHg and explained to Ms Jaconelli the

risks of untreated hypertension. She also booked a GP appointment for the following morning to review Ms Jaconelli's blood pressure and a medication review due to her fasting.

34. On 8 June, at a review with a prison GP, Ms Jaconelli said that she was not taking her medication while she was fasting. She advised that her medication was essential. She changed the prescription to be dispensed at night to accommodate Ms Jaconelli's fasting, noting her blood pressure was particularly high.
35. While changing the prescription, the GP felt that Ms Jaconelli's blood pressure medication seemed disproportionate to her current blood pressure reading, so she decided to prescribe only three of her four antihypertensive medications and to monitor her. Ms Jaconelli said she was content for the prison to obtain information from her cardiologist (but later refused to sign the consent form). The GP requested blood tests, noted the need to continue monitoring Ms Jaconelli's blood pressure and planned to review her the following week.
36. Blood pressure readings on the morning of 8 June were 213/121mmHg and 160/95mmHg. Ms Jaconelli was discharged from the healthcare centre and moved to Houseblock 2 that evening.
37. On 9 June, a mental health nurse assessed Ms Jaconelli and created a risk management care plan. A multidisciplinary team meeting decided that Ms Jaconelli should remain on the nurse's caseload.
38. On 10 June, Ms Jaconelli did not attend a compliance check appointment with a nurse. (Her personal records show that she was with a Listener at that time.) In the afternoon, she did not go out for association with other prisoners and remained in her room. On 11 June, Ms Jaconelli again declined to go out for association as she felt dizzy and wanted to sleep.
39. At 8.15am on 12 June, a wing officer asked a nurse to examine Ms Jaconelli, as she had fainted in her cell and was dehydrated. Ms Jaconelli felt better by the time the nurse arrived. The nurse returned to see her twice more that morning, as she was dizzy and too weak to go to the healthcare centre. Another prisoner told the nurse that Ms Jaconelli was often unsteady on her feet. The nurse unsuccessfully tried to check Ms Jaconelli's blood pressure three times, but did not have a large enough blood pressure cuff.
40. In the afternoon, a prison chaplain explained to Ms Jaconelli that she was exempt from fasting and that, for health reasons, she should not do so.
41. On 13 June, Ms Jaconelli said she was in too much pain and did not feel well enough to attend an induction meeting. On 14 June, she failed to attend for a nurse triage appointment with a nurse.

Events on 15 June

42. Ms Jaconelli did not attend her appointment with a prison GP on the morning of 15 June.

43. At around 2.30pm, a Senior Prison Custody Officer (SPCO) and a mental health nurse went to Ms Jaconelli's cell for an ACCT review. When they arrived, she was unwell so they postponed the review and asked Nurse A to examine her. At interview, the SPCO said Ms Jaconelli appeared drowsy, her eyes were rolling and she could not focus. The SPCO knew that she was diabetic and was concerned that her blood sugar level might be low. However, she noticed a banana skin in the bin, so it appeared that she had eaten something at lunchtime. Although it was a warm day, Ms Jaconelli said she felt cold.
44. Nurse B went to the cell. She noted that Ms Jaconelli was sitting on the side of her bed, supported by an officer and with her head slumped forward. Although she could answer questions, her speech was slow and slightly slurred and her pupils were constricted. Ms Jaconelli told her that she had been on the floor for most of the night and had missed her lunchtime medication. Nurse B asked Nurse A to arrange for Ms Jaconelli to be admitted to the inpatient unit overnight for observation and to stop her evening dose of morphine, as she was concerned that her drowsiness might have been due to having too much morphine. She also noted that the other women on the wing had been looking after Ms Jaconelli since she left the inpatient unit.
45. Nurse A made the request for Ms Jaconelli to be admitted to the healthcare inpatient unit. There were no beds available and staff were waiting for some of the women to be discharged to houseblocks.
46. At 4.30pm, Prison Custody Officer (PCO) A recorded in the ACCT ongoing record that he had tried to speak to Ms Jaconelli but she did not engage. She said she did not feel well and wanted to sleep. He said he asked her if she needed to see the nurse and she said no. At 4.55pm, PCO B recorded in the ACCT document that Ms Jaconelli was on the bed. (CCTV footage does not show any officer going into the cell at the time, but at 5.11pm, an officer glanced through the observation panel while passing the cell.)
47. Ms Jaconelli was last seen alive at 5.11pm, by a prisoner who had collected her evening meal and taken it to her cell. The prisoner said that Ms Jaconelli was asleep and snoring, so she left the meal in her cell.
48. At around 5.15pm, PCO B went to Ms Jaconelli's cell to deliver her 'canteen' (items she had ordered from the prison shop). There was no response when he knocked on her door, so he called PCO A and they both went into the cell. The officers called Ms Jaconelli's name, but she did not respond. She was lying on her right side and PCO A prodded her left shoulder. As there was no response, he told PCO B to radio a code blue medical emergency (which indicates that a prisoner is unresponsive, or has breathing difficulties). The code blue was called at 5.19pm. A short time later, PCO A also called a code blue to be sure the message had got through, as PCO B had left the cell. The control room called an ambulance immediately.
49. Both officers left the cell and called out to a SPCO at the main hub. The SPCO went to the cell, shouted for the officers to get a nurse and then went to get Nurse A from the houseblock pharmacy. When he returned, another SPCO was in the cell and she had started cardiopulmonary resuscitation (CPR), conducting chest compressions.

50. Nurse A and several other nurses then arrived. They applied an oxygen mask and took over the compressions. At 5.21pm, one of the nurses asked for a defibrillator to be brought to the cell. Once attached, it advised them to continue CPR. The first of three ambulances arrived at 5.37pm and the paramedics took over CPR. At 6.35pm, the paramedics confirmed that Ms Jaconelli had died.
51. Prison staff telephoned the prison chaplain at home to find out about appropriate religious rites. She arrived at the prison immediately after Ms Jaconelli was pronounced dead and ensured that key religious processes were observed.

Contact with Ms Jaconelli's family

52. Ms Jaconelli had listed two friends as next of kin. The prison's family liaison officer and the prison chaplain left the prison at 8.40pm to visit her primary next of kin. They informed him that Ms Jaconelli had died and offered condolences and support. As he appeared unwell, they called an ambulance and waited with him until it arrived. (They later found out that he had learning difficulties and arranged for further support.) While they were at his home, they telephoned the other person nominated as next of kin, a mutual friend, who joined them.
53. As Ms Jaconelli was an Irish national, the family liaison officer informed the Irish Embassy of her death. In line with national policy, the prison contributed to the costs of Ms Jaconelli's funeral, which was held on 30 June.

Support for prisoners and staff

54. After Ms Jaconelli's death, the staff involved in the emergency response attended a debrief to ensure they had the opportunity to discuss any issues arising. The staff care team offered support.
55. The prison posted notices informing other prisoners of Ms Jaconelli'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 Jaconelli's death.

Post-mortem report

56. A post-mortem examination confirmed that the cause of Ms Jaconelli's death was hypertensive heart disease, with underlying fatty degeneration of the liver.
57. The post-mortem report noted:

“The blood sample showed the presence of citalopram, lansoprazole, amlodipine, amitriptyline, pregabalin, gabapentin at levels consistent with therapeutic use. Morphine was present at a level of 36 ug/L. The toxicological opinion was ‘the free morphine concentration is low and would not necessarily be expected to cause significant toxicity, even in a naïve user’.”
58. The pathologist concluded that although opiate drugs were detected, the levels would be unlikely to cause significant toxicity and that Ms Jaconelli was morbidly obese with sufficient natural disease to cause death.

Findings

Clinical care

59. Ms Jaconelli had a complex medical history, with several longstanding chronic conditions, and she was regarded as a vulnerable adult due to mental health problems, dyslexia and physical abuse. Healthcare staff at Bronzefield re-prescribed her medication and attempted to monitor her health, although she was not always cooperative.
60. Ms Jaconelli died ten days after arriving at Bronzefield. The investigation found some shortcomings in clinical management, which are highlighted below. However, we agree with the clinical reviewer's conclusion that, overall, Ms Jaconelli's care at Bronzefield was equivalent to that which she could have expected to receive in the community.

Secondary health screen

61. National Institute for Health and Clinical Excellence (NICE) guidelines and Prison Service Order (PSO) 3050, *Continuity of Healthcare for Prisoners*, set out the expectation that prisons ensure continuity of care for prisoners. This includes considering relevant clinical information and carrying out a general health assessment, equivalent to a primary care assessment when registering with a new GP in the community.
62. All new prisoners should be offered a secondary health screen. This is particularly important for those with chronic health conditions. Ms Jaconelli did not have a secondary health screen. The prison said that Ms Jaconelli may have been overlooked because she had been admitted to the inpatient unit immediately after reception. The healthcare department has since taken some steps to allow secondary health screens to be conducted in the inpatient unit. We make the following recommendation:

The Head of Healthcare should ensure that all new prisoners are offered a secondary health screen.

Management of Ms Jaconelli's high blood pressure

63. Ms Jaconelli had a history of high blood pressure. It was poorly controlled as she took her medication irregularly. Her poor compliance continued when she went into prison. She would not take medication while she was fasting during the day and missed medical appointments, so a prison GP adjusted the dispensing times to allow her to take them at night. Ms Jaconelli's blood pressure was taken every day between 5 to 8 June and was mostly raised. The GP noted that it should continue to be monitored, but did not specify the frequency. No further readings were taken, but this might have been due, in part, to Ms Jaconelli's failure to attend some appointments.
64. At interview, a nurse said that she unsuccessfully attempted to take blood pressure readings three times on 12 June, but the cuff attached to the monitor was not large enough to fit Ms Jaconelli's arm. She tried the cuff on her wrist, but was still unable to get a reading.

65. We are concerned that Ms Jaconelli's blood pressure was not monitored in line with the GP's instruction and we agree with the clinical reviewer that such monitoring was important, given Ms Jaconelli's history of high blood pressure. We make the following recommendation:

The Head of Healthcare should ensure that prisoners with high blood pressure are monitored appropriately, in line with NICE guidelines and that monitoring equipment is available in the full range of sizes.

Medical appointments

66. Ms Jaconelli missed appointments with nurses and the prison GP. No reasons were noted in her medical record and they were not followed up. A nurse said that healthcare staff often asked why prisoners did not attend appointments, but this seems to have been an informal arrangement, with no underpinning policy. The healthcare department confirmed that although there is no written policy, healthcare staff try to follow up and rebook appointments, with the help of nurses based on the houseblocks. We make the following recommendation:

The Head of Healthcare should ensure that when prisoners with potentially serious medical problems miss medical appointments, the reasons for non-attendance are recorded and the appointment is rebooked, if necessary.

Monitoring Ms Jaconelli on 15 June

67. Ms Jaconelli was unwell during the afternoon of 15 June. A nurse arranged for her to be admitted to the inpatient unit for closer monitoring, but no beds were available. At that time, beds in the unit were often occupied by prisoners with enduring mental health problems awaiting places at secure psychiatric hospitals and the unit was also used as an 'overspill' if no cells were available in the houseblocks. Healthcare staff had planned to discharge a mental health patient in order to accommodate Ms Jaconelli, but she died before this was completed.
68. Given the concern about Ms Jaconelli's condition, we consider that a nurse should have checked her at regular intervals while she waited for admission to the inpatient unit. The clinical reviewer considered an interim care plan should have been implemented. We make the following recommendation:

The Head of Healthcare should ensure that prisoners waiting to be admitted to the inpatient unit have an interim care plan and are adequately monitored.

Emergency response

69. Two PCOs found Ms Jaconelli unresponsive. They called a code blue emergency and alerted a supervising officer, who arrived shortly afterwards. All three staff then left the cell to get nurses. The supervising officer said that when she arrived the three officers were outside the cell and motioned her in. She then started cardiopulmonary resuscitation.
70. The PCOs were both relatively new to the Prison Service, with less than a year's service. One PCO said that he felt anxious when they found Ms Jaconelli and another PCO felt that getting a nurse was the priority.

71. While we understand that inexperience might have led to slight panic, time is of the essence in an emergency and we are concerned that none of the first three staff at the incident began resuscitation. Given that nurses would have heard the code blue call, it was unnecessary for all three officers to go to find them. We make the following recommendation:

The Director should ensure that operational staff are aware of the importance of starting cardiopulmonary resuscitation at the earliest opportunity when a prisoner is unresponsive; and that staff first on the scene provide basic life support until health professionals arrive, unless there are clear signs of death.

72. In spite of the code blue call, a defibrillator was not automatically taken to the cell. The defibrillator was requested just after nurses started CPR.
73. The prison has reviewed the emergency response procedures and issued guidance to staff, informing them of the location of all the defibrillators and instructing that officers should ensure that the defibrillator is brought to all medical emergencies. In view of this written instruction to address weaknesses in the emergency response procedures, we make no recommendation on this issue.

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