

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mrs Serena Nicolle a prisoner at HMP Bronzefield on 3 September 2018

A report by the Prisons and Probation Ombudsman

Our Vision

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

Our Values

We are:

Impartial: *we do not take sides*

Respectful: *we are considerate and courteous*

Inclusive: *we value diversity*

Dedicated: *we are determined and focused*

Fair: *we are honest and act with integrity*



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

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

Mrs Serena Nicolle died on 3 September 2018 of heart disease at HMP Bronzefield. Mrs Nicolle was 52 years old. I offer my condolences to Mrs Nicolle's family and friends.

Mrs Nicolle had only been at Bronzefield for four days when she was found dead in her cell. Her behaviour was violent and unpredictable and as a result healthcare staff had been unable to examine her in person during the short time she was at Bronzefield. She also declined to take her medication. A multi-disciplinary meeting to decide how to deliver healthcare in these difficult circumstances was taking place when she died.

Although Mrs Nicolle had some significant physical and mental health conditions, the clinical reviewer is satisfied that she did not require immediate active management and that staff could not reasonably have foreseen her death from heart disease. The clinical reviewer is satisfied that the care she received at Bronzefield met the required professional standards.

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

Sue McAllister, CB
Prisons and Probation Ombudsman

December 2019

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Summary

Events

1. On Friday 31 August 2018, Mrs Serena Nicolle was charged with assault. The court remanded her into custody and she was transferred to HMP Bronzefield. This was her first time in prison.
2. A nurse reviewed Mrs Nicolle at a reception health screen. She noted that Mrs Nicolle had some significant physical and mental health conditions: sleep apnoea, Type 2 diabetes and bipolar disorder. Mrs Nicolle had her prescribed medication with her. The nurse recorded that Mrs Nicolle was violent and unpredictable and posed a risk to others. She was located in the healthcare unit.
3. Mrs Nicolle declined to take her medication or engage with healthcare staff at Bronzefield. The day after she arrived, a prison GP decided not to examine her in person after prison officers advised that she posed a risk. Later, Mrs Nicolle hit a nurse who attempted to examine her. Over the weekend, healthcare staff and officers monitored Mrs Nicolle's wellbeing from outside her cell. Staff reported no concerns.
4. On the afternoon on Monday 3 September, a multidisciplinary team meeting was held to discuss Mrs Nicolle's care. While this meeting was taking place, an officer saw Mrs Nicolle on the floor of her cell. He called a nurse but they were unable to get a response. Due to Mrs Nicolle's risk, they summoned help from other officers. A manager entered her cell and immediately realised that Mrs Nicolle was unresponsive. At 4.39pm, the manager called an emergency medical code over the radio. The prison requested an ambulance immediately while healthcare staff provided life support.
5. At 4.50pm, an ambulance crew arrived and took over life support. At 5.25pm, a prison GP pronounced Mrs Nicolle dead.

Findings

Clinical care

6. Healthcare staff were unable to assess Mrs Nicolle in person due to her violent and unpredictable behaviour. However, they kept her under observation over the weekend and monitored her for signs of an acute phase in her illnesses.
7. A multidisciplinary meeting to discuss how to deliver healthcare to Mrs Nicolle was taking place when she was found dead.
8. The clinical reviewer is satisfied that the care Mrs Nicolle received at Bronzefield met the required professional standards. She had significant mental and physical health concerns which required attention, but not immediate attention. There was no reason to believe that she was at immediate risk of dying.
9. We are concerned that a prison GP believed that it was for operational staff to decide if she was allowed to enter Mrs Nicolle's cell to carry out an examination and did not understand that it was her responsibility as a clinician to ask

operational staff to make arrangements for her to examine Mrs Nicolle if she considered it clinically necessary.

10. A nurse was the inpatient unit healthcare staff member on duty over the weekend. We share the clinical reviewer's view that she deserves praise for her efforts in dealing with what was a very complex case.
11. We are concerned that the nurse did not receive a reply when she emailed senior managers on Sunday 2 September seeking support, though we note that the prison's IT department have been unable to trace any email sent by the nurse or any of her colleagues to senior healthcare managers.
12. We are also concerned that a prison GP mistakenly made a record about another prisoner in Mrs Nicolle's medical records.

Emergency response

13. We are satisfied that the prison responded appropriately when Mrs Nicolle was discovered unresponsive. We recognise that an emergency code was not called immediately but accept that staff were understandably wary of the risk Mrs Nicolle posed and sought back up before entering her cell to check her wellbeing. Back up staff were close at hand and arrived very quickly.

Recommendations

- The Director and Head of Healthcare should ensure that all prison and healthcare staff (including GPs) understand that the decision on whether healthcare staff need to see a prisoner in person to make an assessment or deliver treatment is a clinical decision, and that if healthcare staff consider it clinically necessary, operational staff should facilitate it after making appropriate arrangements where necessary.
- The Head of Healthcare should ensure that healthcare staff are able to obtain timely managerial support when required outside of normal working hours.
- The Head of Healthcare should remind clinical staff, including GPs, of their responsibilities to keep accurate and precise clinical records.

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 him. No one responded.
15. The investigator visited Bronzefield on 11 September 2018. He obtained copies of relevant extracts from Mrs Nicolle's prison and medical records and interviewed four members of staff and one prisoner.
16. NHS England commissioned a clinical reviewer to review Mrs Nicolle's clinical care at the prison. The investigator and clinical reviewer interviewed a further member of staff by telephone on 31 October. Both of them and a member from of staff from the PPO visited Bronzefield on 8 January 2019, where they interviewed a further two members of staff.
17. We informed HM Coroner for Surrey of the investigation. He gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
18. The investigator contacted Mrs Nicolle's husband to explain the investigation and to ask whether he had any matters he wanted the investigation to consider. He raised no concerns about Mrs Nicolle's care in the prison but said that he had told the court that Mrs Nicolle needed to be in a hospital not a prison. We have not addressed this point in our report as it is outside the Ombudsman's Terms of Reference.
19. Mrs Nicolle's sister contacted the investigator and asked to be kept informed about the investigation. She did not raise any specific concerns about her sister's care in the prison.
20. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies and this report has been amended accordingly.
21. Mrs Nicolle's husband and sister received a copy of the initial report. The solicitor representing Mrs Nicolle's husband wrote to us pointing out some factual inaccuracies and/or omissions. The report has been amended accordingly. They also raised a number of questions that do not impact on the factual accuracy of this report. We have provided clarification by way of separate correspondence to the solicitor.
22. The solicitor representing Mrs Nicolle's sister wrote to us pointing out some factual inaccuracies and/or omissions. The report has been amended accordingly. They also raised a number of questions that do not impact on the factual accuracy of this report. We have provided clarification by way of separate correspondence to the solicitor.

Background Information

HMP Bronzefield

23. HMP Bronzefield near Heathrow Airport is a female prison holding up to 557 prisoners, including young offenders and restricted status prisoners (those considered to pose a serious risk to the public). The prison serves 90 courts, and takes both remand and sentenced prisoners.
24. The prison is privately-run, managed by Sodexo Justice Services Ltd. Nursing staff are employed directly by the prison, with agency nurses used if required. GP services are provided by a private company, Cimarron UK, and the mental health in-reach team is provided Central and North West London NHS Foundation Trust. There is an 18-bed inpatient wing in the healthcare unit.

HM Inspectorate of Prisons

25. The most recent inspection of HMP Bronzefield was conducted in December 2018. Inspectors reported that the prison was an excellent institution with prisoners experiencing outcomes which exceeded their measures for a healthy prison. They reported that prisoners were welcomed on reception and properly inducted and risk assessed.
26. Inspectors said that the inpatient unit was well managed, and they observed caring and compassionate interactions with patients with complex problems.

Independent Monitoring Board

27. 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 2018, the IMB reported that overall, prisoners were treated fairly, humanely and with decency.
28. The Board reported that many healthcare inpatient beds were taken up with prisoners experiencing mental health issues. It also noted that many prisoners were housed in the unit because they were deemed vulnerable and there was nowhere better to accommodate them. The Board commended the staff on the unit, and said that they did an exceptional job in very demanding circumstances.

Previous deaths at HMP Bronzefield

29. Mrs Nicolle was the fourth prisoner to die at Bronzefield since January 2017. We have found no similarities between her death and these earlier ones.

Key Events

30. On Friday 31 August 2018, Mrs Serena Nicolle was charged with assault. The court remanded her in custody before she was transferred to HMP Bronzefield. This was her first time in prison.
31. Mrs Nicolle's escort form documented that she was extremely violent and had attacked officers while in police custody. It also recorded that she had previously self-harmed by cutting her wrists with a knife. Mrs Nicolle's paperwork also recorded that she suffered with sleep apnoea, Type-2 diabetes, depression and bipolar panic attacks (for which she had spent time in a psychiatric hospital). The form noted that she had prescribed medication with her.

Friday 31 August

32. At 1.55pm, Mrs Nicolle arrived in reception at Bronzefield. At 3.11pm, a nurse performed her reception health screen. She recorded that Mrs Nicolle suffered with bipolar disorder, had medication for diabetes, and had a machine to assist her sleep apnoea. She also recorded that she was extremely violent and had hit an officer and a nurse while waiting to be seen in reception. She recorded that Mrs Nicolle was to be located in the healthcare unit because she was so unpredictable and posed a high risk.
33. A nurse in the healthcare unit that evening, was accompanied by prison officers. In interview, she said she went to introduce herself to Mrs Nicolle and to attempt to administer her medications. She said that Mrs Nicolle declined mediation and told her not to come into her cell, so she spoke to her through the cell hatch. She drew up a diabetes care management plan and a bipolar care management plan and recorded in Mrs Nicolle's medical notes that staff should monitor and record her mood and behaviour, as well as her eating and sleeping patterns, and that she should be assessed by the mental health team. The nurse said that this entry was intended for both healthcare and prison staff and to assist the mental health team.
34. The nurse was also the designated emergency response nurse for the prison that evening. She said that she was very busy so checked on Mrs Nicolle whenever she could. She said that she did not record every occasion she checked on Mrs Nicolle because there was no medical computer in the healthcare unit.
35. At 6.32pm, a prison GP recorded that she had been asked to issue Mrs Nicolle's repeat prescriptions. She noted that she was unable to see Mrs Nicolle in person but reviewed the medication she had with her on admission. The prison GP suspected that Mrs Nicolle had not been taking her medication in the community and advised that she be reviewed in person the next day. Mrs Nicolle's husband confirmed that the prison GP's suspicion was incorrect and Mrs Nicolle took her medication in the community.

Saturday 1 September

36. The following morning, a nurse returned to duty. She initially performed medication duty, which involved handing out medication to prisoners who needed it. She then ran a clinic. At 10.12am, she recorded that Mrs Nicolle had thrown

porridge at an officer that morning in an unprovoked attack. She noted that Mrs Nicolle was subject to a three officer unlock due to the risk she posed. (A three officer unlock means that three officers had to be present before Mrs Nicolle's cell could be unlocked.) She recorded that Mrs Nicolle required ongoing monitoring.

37. At 12.22pm, a prison GP made an entry in Mrs Nicolle's medical notes. In interview, she said that she had incorrectly entered the notes from a consultation with a different prisoner who she saw around the same time. She recalled in interview that officers had advised her not to enter Mrs Nicolle's cell so she spoke to her through her cell hatch. She said that Mrs Nicolle declined to engage with her so she was unable to perform a proper review. She was also unable to examine her because she was prevented from entering her cell. She asked that clinical observations be performed daily and for healthcare staff to be advised of any changes in Mrs Nicolle's physical health.
38. At 2.50pm, a nurse saw Mrs Nicolle after she complained of dizziness, diarrhoea and vomiting. She recorded that she entered Mrs Nicolle's cell with three officers to examine her. In interview, the nurse said that when she tried to check Mrs Nicolle's blood pressure, Mrs Nicolle hit her hard in the face, so they withdrew from the cell. At interview, she said the blow caused quite marked swelling and bruising which lasted several days. She said that due to Mrs Nicolle's health concerns, she did not consider that it would have been appropriate to restrain her in order to examine her.
39. At 6.13pm, the nurse went to give Mrs Nicolle her medication and spent 15 minutes communicating with her through the hatch. She recorded that Mrs Nicolle spat her medication on the floor and that she thought her behaviour was unpredictable and that it was too risky to enter her cell. She recorded that Mrs Nicolle's sleep apnoea machine had arrived but that it would remain in the office until it was safe to put it in her cell.
40. A Prison Custody Officer (PCO) was on day shift duty over the weekend. In interview, he said that officers were concerned about Mrs Nicolle so conducted random observations on her but did not formally record these.
41. During the night, a healthcare assistant was on duty. At 11.25pm, she noted that Mrs Nicolle was continually activating her cell bell. At 6.16am the next morning, she noted that Mrs Nicolle appeared settled overnight with no concerns reported.

Sunday 2 September

42. At 1.35pm on 2 September, a nurse recorded that Mrs Nicolle pretended to take her medication but placed it on the desk in her cell and refused to bring it back to the hatch. She recorded that due to her assessment of the risk, Mrs Nicolle's medication was to be withheld. In interview, she said that Mrs Nicolle had arrived at Bronzefield with medication but had not taken it for a few months, and she feared Mrs Nicolle might stockpile her medication in her cell and overdose. She was also concerned that Mrs Nicolle might be trying to staff into the cell (to retrieve the medication) to attack them.

43. The nurse told us that she asked a colleague to send an email to senior healthcare managers at around 2.00pm on Sunday to express her concerns about the risks to Mrs Nicolle's mental and physical health if her medication could not be administered and the risks Mrs Nicolle posed to staff, and to request a plan to manage the situation until Monday morning. She said she could not recall getting a reply, though the prison's IT department have been unable to trace any email sent by the nurse or any of her colleagues to senior healthcare managers.
44. At 5.35 pm, the nurse recorded that it was again unsafe to give medication because Mrs Nicolle was standing by her cell hatch and refusing to go to her bed so that medication could be safely delivered through the hatch.
45. At 6.24pm, she recorded that she had spent 15 minutes in face to face contact speaking to Mrs Nicolle through the hatch.
46. The healthcare assistant again worked the nightshift. She recorded two observations of Mrs Nicolle during the night, noting that she had no concerns.

Monday 3 September

47. On 3 September, a nurse made a retrospective entry on Mrs Nicolle's medical records at 5.58pm. She recorded that at 8.00am, she had discussed Mrs Nicolle's care at a morning handover meeting with the Head of Healthcare, the deputy Head of Healthcare and the mental health team all in attendance. The nurse noted that she had explained the need for a risk management plan and proper supervision to ensure that Mrs Nicolle took her medication. She also noted that Mrs Nicolle had again declined medication that morning. After the meeting, she discussed obtaining Mrs Nicolle's community health records with the practice manager, who said that they would seek consent from Mrs Nicolle's husband. She noted that these records were received at approximately 3.30pm that day.
48. At approximately 4.30pm, a multidisciplinary meeting was held to discuss Mrs Nicolle's care. Those present were a residential manager, a Senior Prison Custody Officer (SPCO), a nurse, a team manager from the prison's mental health in-reach team, and a PCO. The team manager recorded that they discussed a plan to administer Mrs Nicolle's medication safely but were interrupted before they had finished.
49. A PCO was on duty in the healthcare wing that day. In interview, he said that officers would have seen Mrs Nicolle at approximately 12.45pm, during the lunchtime roll checks. The PCO said that officers would also have performed other random checks during the afternoon but would not have made a record if there was no cause for concern. CCTV shows the PCO observing Mrs Nicolle at approximately 3.43pm and again at 4.11pm.

Emergency response

50. At approximately 4.30pm, the PCO saw Mrs Nicolle lying on the floor of her cell during a random observation. In interview, he said that everyone was in an office on the healthcare wing having a meeting. He went to the office and asked a nurse to check on Mrs Nicolle. The PCO said that they received no response

when they called to her from outside her door, and he was aware that Mrs Nicolle was on a three person unlock. He therefore returned to the office and asked his manager and other staff to assist.

51. The nurse said that the PCO called her out of the meeting to check on Mrs Nicolle. CCTV shows that she and the PCO looked through Mrs Nicolle's observation panel at 4.31pm. She said that Mrs Nicolle was lying on the floor of her cell with the blankets from her bed obscuring her face. She said that she did not respond to their calls, but that she saw movement in Mrs Nicolle's stomach. She asked the PCO to get assistance because she was wary of entering Mrs Nicolle's cell without adequate security. The PCO went back to the office and returned at 4.33pm with the residential manager, and several more officers and healthcare staff.
52. In interview, the residential manager said that an officer had said that they could see Mrs Nicolle breathing but that she looked unwell. CCTV shows that the residential manager unlocked the cell at 4.35pm and went in, together with a SPCO. The residential manager said that as soon as she approached Mrs Nicolle, she noticed that her face was blue. She immediately called a code blue emergency. (A code blue call is an emergency radio code which indicates someone is unconscious or having problems breathing. It triggers the immediate attendance of healthcare staff and the control room to call for an ambulance.)
53. The control room log records that a code blue emergency was called at 4.39pm and that a control room operator immediately called for an ambulance. The South East Coast Ambulance Service log confirmed that they received the call at 4.39pm. CCTV shows that paramedics reached Mrs Nicolle at 4.49pm, though the Ambulance Service log recorded this as 4.52pm.
54. The nurse went to collect the emergency equipment, which she said was just four doors from the cell. When she returned, Mrs Nicolle had been moved to the centre of her cell. She checked Mrs Nicolle and said she was not breathing and had no pulse. She asked officers to move Mrs Nicolle into the corridor so that she had more room. She started cardiopulmonary resuscitation (CPR) while other staff fetched the defibrillator and prepared oxygen. The defibrillator was attached but did not advise a shock at any point. She continued CPR until the ambulance arrived.
55. A prison GP was on duty but had been dealing with another emergency. She was not called to Mrs Nicolle but came to see her subsequently. She said that when she arrived, paramedics were providing life support to Mrs Nicolle. She said that she was present for only ten minutes before paramedics called an end to resuscitation.
56. The prison GP pronounced Mrs Nicolle dead at 5.25pm.

Post-mortem report

57. Mrs Nicolle's post-mortem concluded that she died from ischaemic (reduced blood supply) and hypertensive heart disease. The post-mortem also recorded that diabetes and sleep apnoea were secondary causes of death.

Contact with Mrs Nicolle's family

58. Mrs Nicolle's next of kin was her husband. The prison appointed a SPCO as the prison's family liaison officer (FLO), with a member of staff from the Diversity Team as the deputy family liaison officer.
59. Shortly before 8.00pm on 3 September, the FLO and deputy FLO broke the news of Mrs Nicolle's death to her husband at their family home. Mrs Nicolle's mother-in-law was also there and Mrs Nicolle's daughter arrived shortly afterwards. Both explained their role and offered support.
60. On 5 September, the deputy FLO returned Mrs Nicolle's sister's call after she left a voicemail. She continued to liaise with her as well as Mrs Nicolle's husband.
61. Mrs Nicolle's funeral was held on 27 September 2018. The prison contributed to the costs in line with national guidance.

Support for prisoners and staff

62. After Mrs Nicolle's death, the Deputy Director debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.
63. The prison posted notices informing other prisoners of Mrs Nicolle'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 Mrs Nicolle's death.

Findings

Clinical care

64. The clinical reviewer concluded that, overall, the care Mrs Nicolle received at Bronzefield met the required professional standards. He noted that Mrs Nicolle was only in the prison for four days and that, although she had medical concerns that required attention, they did not require immediate attention and that there was no reason to believe she was at imminent risk of dying.

Healthcare reception and assessment of Mrs Nicolle

65. Prison Service Instruction (PSI) 07/2015, *Early Days in Custody*, requires that any new prisoner must be seen on reception to determine any health risks or other concerns. The PSI states that:

“All incoming prisoners must be medically examined, in private if possible, by a qualified member of the Healthcare team, or a competent and trained Health Care Assistant... to determine whether they have any short or long term physical or mental health needs... and ensure that any follow up action is taken, that anyone who needs to know about individual prisoner’s ongoing healthcare requirements is informed, and that actions taken are recorded in the appropriate record.... Prisoners spending their first night in the current prison... may undergo the detailed medical assessment on the following day, (or if this is not possible, no later than one week after arrival) unless there are urgent health issues that must be addressed on the day of arrival.”

66. Mrs Nicolle had a first reception health assessment on her arrival at Bronzefield. This identified three significant health concerns: diabetes, sleep apnoea and bipolar disorder. It also identified that she was unpredictable, violent and a risk to others. She was appropriately located in the healthcare unit due to her being a high risk.

67. Mrs Nicolle presented as a risk to staff and others following her admission to Bronzefield. The clinical reviewer referred to the General Medical Council publication on the duties of a doctor, citing Duty 58, which states that doctors:

“must not deny treatment to patients because their medical condition may put you at risk. If a patient does pose a risk to your health and safety, you should take all reasonable steps to minimise the risk before providing treatment or making other suitable alternative arrangements for providing treatment.”

68. A prison GP said that she did not examine Mrs Nicolle in person the day after her admission because prison officers advised her that it was not safe to enter her cell. A couple of hours later, a nurse entered the cell and attempted to examine Mrs Nicolle after she reported being unwell but had to retreat from the cell after Mrs Nicolle hit her. She subsequently decided that it was too risky for her to enter Mrs Nicolle’s cell again to examine her over the weekend. As a result, healthcare staff did not perform a full medical examination of Mrs Nicolle before her death.

69. We are satisfied that it was reasonable for the nurse not to enter the cell again after Mrs Nicolle hit her on the Saturday afternoon. We are also satisfied that she continued to attempt to assess Mrs Nicolle by checking her and attempting to engage with her at some length from outside the cell over the weekend. We are also satisfied that prison staff checked Mrs Nicolle's wellbeing regularly. We note, for example, that immediately prior to Mrs Nicolle's death, CCTV shows a PCO checking her at 3.43pm, 4.11pm and 4.30pm (when he saw her lying on the floor).
70. The clinical reviewer is satisfied that healthcare staff managed Mrs Nicolle's three chronic health conditions appropriately over the weekend. He said that although she had several complex physical and mental health concerns, nothing indicated that she was at an imminent risk of death, or that she required immediate medical attention. He concluded that staff took the correct decision not to allow Mrs Nicolle to have her sleep apnoea machine in her cell while she was acting unpredictably. The machine is used to protect the heart from long-term damage, but it was not essential to use it every night, and Mrs Nicolle could have damaged it or used it as a weapon to harm staff. With regard to her diabetes, the clinical reviewer concluded that staff had recorded an acceptable blood sugar level on her admission to Bronzefield and that Mrs Nicolle was unlikely to suffer acute deterioration over the weekend. The clinical reviewer also concluded that although Mrs Nicolle's mental health could deteriorate without her medication, she had not been taking her medication in the community for some time, so the risk was minimal. He was also satisfied that the nurse was confident that she would recognise an acute phase of this illness and was regularly monitoring Mrs Nicolle during the weekend.
71. We are, however, concerned that a prison GP said that prison staff told her she was 'not allowed' to enter Mrs Nicolle's cell to examine her on the Saturday afternoon because of the risk she posed. The residential manager told us that if healthcare staff consider that they need to examine a prisoner in person, prison staff need to facilitate this, even if that means entering the cell in full personal protection kit.
72. We do not say that a prison GP should have entered the cell, or that doing so would have affected the outcome for Mrs Nicolle, but we are concerned that she did not understand that it was her responsibility to tell prison staff that she needed to examine Mrs Nicolle in person if she thought it clinically necessary. We recognise that there will be some circumstances where it is not safe for healthcare staff to enter a cell. Where this is the case but healthcare staff still consider it is necessary to examine the prisoner, prison staff must facilitate that. Alternative arrangements may need to be made: for example, the examination may take place later, in a different location (such as a secure visits room), under restraint, or in the presence of someone the prisoner trusts.
73. We note that a nurse entered the cell to examine Mrs Nicolle a couple of hours later on the Saturday, accompanied by three prison officers.
74. We recommend:

The Director and Head of Healthcare should ensure that all prison and healthcare staff (including GPs) understand that the decision on whether healthcare staff need to see a prisoner in person to make an assessment or

deliver treatment is a clinical decision, and that if healthcare staff consider it clinically necessary, operational staff should facilitate it after making appropriate arrangements where necessary.

75. The nurse is very experienced: she is registered both as a general nurse and as a mental health nurse and has worked in the prison setting since 2004. She told us that she felt that the combination of trying to manage Mrs Nicolle's behaviour, her mental health needs and her physical health needs represented the most complex new admission to prison that she had ever had to care for. She was one of ten nurses on duty over the weekend (six on Saturday and four on Sunday) but the only one allocated to the healthcare unit, though the prison considers that this is adequate in line with their staffing profile. The clinical reviewer said that, although she did not say so herself, he gained the impression of a nurse trying to do her best in very difficult circumstances, perhaps, at times, wishing for more support. He concluded that her practise met the highest professional standards.
76. We share the clinical reviewer's view and we also share his concern that when the nurse sought support from management via an email on Sunday 2 September, she did not receive a reply. Though we note that the prison's IT department have been unable to trace any email sent by her or any of her colleagues to senior managers. We recommend:

The Head of Healthcare should ensure that healthcare staff are able to obtain timely managerial support when required outside of normal working hours.

Community medical records

77. PSI 07/2015 also states:

"Efforts should be made to retrieve any information required from the prisoner's GP, or other relevant service the prisoner has recently been in contact with, normally with the prisoner's consent."

78. Mrs Nicolle arrived at Bronzefield on a Friday, so staff were unable to obtain her medical records from her community GP over the weekend. She also declined to cooperate with medical staff and did not consent to her records being obtained. However, Mrs Nicolle's husband gave his consent and her GP records were received by Monday afternoon, which was the first working day after her imprisonment.
79. We are satisfied that staff acted appropriately in obtaining Mrs Nicolle's medical records as promptly as they did.

Medical record keeping

80. We note that a nurse did not complete entries for each occasion she saw Mrs Nicolle but summarised these in retrospective entries. She explained to us that there was no medical computer on the healthcare wing at the time. The prison has told us that, following its own investigation into Mrs Nicolle's death, a medical computer has now been installed on the wing.

81. We are concerned that a prison GP mistakenly recorded a clinical entry about another prisoner in Mrs Nicolle's medical notes. We are also concerned that this error was not spotted until the issue arose during our investigation. While this is unlikely to have caused any problems in this instance, it is important to ensure that entries are accurately recorded. We make the following recommendation:

The Head of Healthcare should remind clinical staff of their responsibilities to keep accurate and precise clinical record.

Emergency response

82. Prison Service Instruction (PSI) 03/2013, *Medical Response Codes*, requires prisons to have a two-code medical emergency response system in place. Calling an emergency medical code should automatically trigger healthcare staff to attend and the control room to call an ambulance.
83. When a PCO first became concerned about Mrs Nicolle, he immediately went in person to fetch a nurse who was in the unit at a meeting. Given Mrs Nicolle's unpredictable and violent history, the nurse asked the PCO to fetch assistance so that they could unlock her cell and assess her. As soon as the residential manager unlocked and entered Mrs Nicolle's cell, she called a code blue emergency and an ambulance was requested.
84. Under a strict reading of the PSI, a code blue should have been called as soon as Mrs Nicolle was seen lying on the floor unresponsive by A PCO and then a nurse. However, we accept that both were very aware of Mrs Nicolle's behaviour, and that she had been acting unpredictably during the weekend and might be trying to lure staff into the cell to attack them. We accept that they were justified in being wary of entering Mrs Nicolle's cell without appropriate back-up. In these very specific circumstances, we accept that it was reasonable for the PCO and nurse to seek assistance from other staff before entering the cell and checking on Mrs Nicolle.
85. We are also satisfied that once the emergency response was triggered, healthcare staff and officer acted promptly and appropriately in providing CPR. Staff also ensure that the ambulance crew were with Mrs Nicolle promptly.
86. Overall, we are satisfied with the emergency response and make no recommendations.
87. From reviewing CCTV and the control room log, it is clear that there is a disparity between the times recorded and we have been unable to define which, if either, is accurate. This in turn means we cannot be sure whether the code blue was called at 4.39pm or earlier. However, CCTV shows that there was a 14-minute period between staff entering Mrs Nicolle's cell and paramedics arriving. The South East Coast Ambulance Service log notes that there was a 13-minute period between receiving the emergency call from the prison and paramedics arriving. Due to the similarity in timings, we are satisfied that the code blue was called promptly and that an ambulance was immediately called.

Contact with Mrs Nicolle's family

88. We are satisfied with the prison's contact with Mrs Nicolle's family. The prison promptly informed Mrs Nicolle's husband of her death. It then appropriately liaised with her sister after she indicated that she wanted to be involved.

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