Prisons &
Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Ms Joanne Harrison, a prisoner at HMP Eastwood Park, on 23 November 2019

A report by the Prisons and Probation Ombudsman

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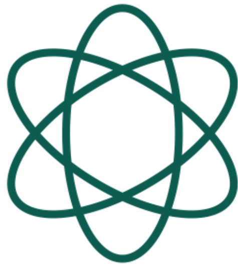
Our vision

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

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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 Joanne Harrison died from the toxic effects of a combination of prescription drugs on 23 November 2019, at HMP Eastwood Park. She was 46 years old. I offer my condolences to Ms Harrison's family and friends.

Ms Harrison arrived at Eastwood Park on 19 November. She had a history of drug and alcohol misuse and was put on a methadone programme and an alcohol detoxification programme. She was also taking a range of prescription drugs when she arrived at Eastwood Park. A prison GP noted that Ms Harrison might have liver cirrhosis (liver damage) and that the combination of drugs she was taking could be potentially toxic, so he stopped one medication and reduced another.

The clinical reviewer was satisfied that the clinical care Ms Harrison received at Eastwood Park was equivalent to that she could have expected to receive in the community. He considered that the prison GP had correctly identified concerns with her prescribed medication and responded appropriately.

The investigation did identify some concerns though. Although Ms Harrison was monitored by nurses after she started her detoxification, she was not reviewed by a prison GP. Also, despite healthcare staff noticing that Ms Harrison appeared to be 'over-sedated', no one referred her to a GP, or told prison staff.

The investigation identified some delays with the emergency response when staff realised that Ms Harrison was not breathing. While I am satisfied that the delays are unlikely to have affected the outcome for Ms Harrison, it is important that staff respond promptly to a medical emergency and follow the correct procedures, so that potentially life-saving treatment can be administered without delay.

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

Sue McAllister CB
Prisons and Probation Ombudsman **August 2020**

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Summary

Events

1. On 19 November 2019, Ms Joanne Harrison was remanded in custody charged with assault, and sent to HMP Eastwood Park.

2. Ms Harrison had a history of drug and alcohol misuse. When she arrived at Eastwood Park, she was already on a methadone (opiate substitute) programme in the community and was taking various different prescription drugs for a range of conditions. A prison GP noted that Ms Harrison might have liver cirrhosis and that the drugs she was taking could be potentially toxic, so he stopped one of her medications and reduced another. Ms Harrison was put on a methadone programme and an alcohol detoxification programme, and was monitored daily by nurses.

3. On 20 and 22 November, nurses noted that Ms Harrison appeared to be 'over-sedated' or intoxicated. They withheld her medication on 22 November.

4. On 23 November at 3.19am, a nurse looked into Ms Harrison's cell and was concerned because she could not see her breathing. She asked an operational support grade (OSG) to go back to the cell with her.

5. He could not see Ms Harrison breathing either, so he used the nurse's radio to ask for an officer to attend. He then asked the night manager for permission to go into the cell but was told to wait as the manager was on his way.

6. The night manager arrived at 3.26am, and a minute later, asked for an ambulance to be called. Staff and paramedics attempted resuscitation but, at 4.10am, paramedics declared Ms Harrison had died.

7. The post-mortem report concluded that Ms Harrison died from the toxic effects of a combination of prescription medication. It noted that her liver cirrhosis (scarring of the liver caused by long-term liver damage) was likely to have increased the risk of toxic effects from some of the medication.

Findings

8. The clinical reviewer found that the clinical care Ms Harrison received at Eastwood Park was of a reasonable standard and was equivalent to that she could have expected to receive in the community. He noted that the prison GP correctly identified that the combination of drugs Ms Harrison was taking could be potentially toxic and he responded appropriately by stopping one medication and reducing another.

9. The clinical reviewer did, however, identify some concerns.

10. The GP did not arrange to review Ms Harrison as he should have done and relied on nurses to report any concerns with her detoxification.

11. There were several occasions when nurses noted that Ms Harrison appeared to be intoxicated. However, they did not arrange a GP review, tell prison staff, or submit intelligence reports.

12. The OSG who accompanied the nurse to Ms Harrison's cell in the early hours of 23 November, was unable to use his radio to call for assistance because his radio battery was flat. He used the nurse's radio instead, but it is still of concern that his own radio was not working.

13. Both the OSG and the nurse failed to use a medical emergency code as they should have done. The prison has since reissued guidance on using emergency codes.

14. There was an unnecessary delay in entering Ms Harrison's cell while the OSG waited for the night manager to arrive. The OSG had a key to the cell and, given Ms Harrison was not responding and did not appear to be breathing, we consider he should have entered the cell, with the nurse, sooner.

15. We do not consider that the night manager should have told the OSG to wait until he arrived before entering the cell.

16. None of the staff who attended Ms Harrison's cell in response to the call for assistance used their body-worn video cameras (BWVCs) to record the incident.

17. There is no indication that Ms Harrison intended to take her life and it appears that her death was accidental. However, there were failings in the reception process at Eastwood Park, particularly around assessing the risk of suicide and self-harm, which we consider we should highlight. We understand that according to local guidance, reception staff should have started suicide and self-harm prevention procedures (known as ACCT) because Ms Harrison had self-harmed in the past. We are concerned, however, that the local guidance to healthcare staff is not in line with national guidance on managing prisoners at risk and have recommended that this is reviewed.

Recommendations

- The Head of Healthcare should review the policy on GPs conducting follow up visits for prisoners undergoing a detoxification programme.
- The Head of Healthcare should ensure that healthcare staff:
  - complete full clinical observations when a prisoner on a detoxification programme appears over-sedated or intoxicated; and
  - refer the prisoner to a GP for review.
- The Governor and Head of Healthcare should ensure that healthcare staff have improved access to NOMIS.
- The Head of Healthcare should ensure that healthcare staff:
  - tell prison staff if a prisoner on a detoxification programme appears over-sedated or intoxicated;
  - record that they have done so in the prisoner's medical record; and

- complete an intelligence report.

- The Head of Healthcare should share this report with the nurse who was on night duty on Kinnon Unit on 22/23 November and discuss the Ombudsman's findings with her.
- The Governor should ensure that arrangements are in place to enable officers to replace or recharge radio batteries before their shift ends, including at night.
- The Governor should ensure that staff enter a prisoner's cell immediately in a medical emergency, where it is safe to do so.
- The Governor should ensure that night orderly officers understand that, in a medical emergency, staff do not need to seek their permission or wait for them to arrive before they enter the cell.
- The Governor should share this report with the OSG who was on night duty on Kinnon Unit on 22/23 November and with the CM who was night manager and arrange for a senior manager to discuss the Ombudsman's findings with them.
- The Governor should ensure that sufficient numbers of staff are assigned to wear BWVCs, on day and night shifts, and that they activate them at the earliest opportunity during any reportable incident.
- The Head of Healthcare should revise the guidance contained in *Improving sharing of information in Assessment, Care in Custody and Teamwork (ACCT) documents – prisons workbook* to bring it in line with national guidance in PSIs 07/2015 and 64/2011 on when ACCT procedures should be started.
- The Governor and Head of Healthcare should produce clear guidance about procedures for identifying prisoners at risk of suicide and self-harm. In particular, this should ensure that reception, healthcare, first night staff and all others who assess risk:
  - have a clear understanding of their responsibilities and the need to share all relevant information about risk;
  - consider and record all known risk factors of a newly-arrived prisoner when determining their risk of suicide and self-harm, including information from the Person Escort Record (PER) and other sources; and
  - document the information considered and the reasons for the decision on whether or not to start ACCT procedures.

The Investigation Process

18. The investigator issued notices to staff and prisoners at HMP Eastwood Park informing them of the investigation and asking anyone with relevant information to contact her. Nobody responded.

19. The investigator visited Eastwood Park on 27 November 2019. She obtained copies of relevant extracts from Ms Harrison's prison and medical records. She visited the unit where Ms Harrison lived and spoke to staff and prisoners that had contact with her.

20. NHS England commissioned an independent clinical reviewer to review Ms Harrison's clinical care at the prison.

21. The investigator interviewed three prisoners at Eastwood Park during her initial visit. She and the clinical reviewer interviewed six members of staff on 17 December and the investigator interviewed six members of staff on 18 December. In addition, the investigator interviewed two prison staff by telephone in January 2020.

22. We informed HM Coroner for Avon of the investigation. The Coroner gave us the cause of death. We have sent the Coroner a copy of this report.

23. One of the Ombudsman's family liaison officers contacted Ms Harrison's next of kin to explain the investigation. Ms Harrison's next of kin wanted to know if she was receiving the correct dose of methadone.

24. The investigator also spoke to Ms Harrison's next of kin who also wanted to know if Ms Harrison was receiving the correct dose of methadone.

25. Ms Harrison's next of kin received a copy of the initial report. She did not identify any factual inaccuracies.

26. The prison also received a copy of the report and did not identify any factual inaccuracies. An action plan for the recommendations is annexed to the report.

27. The Prison Group Director for the female estate requested a review of clinical care at the prison for his own management purposes, which was completed by a doctor. As this review covers much of the same ground as the clinical reviewer's review, we have attached a copy to this report. (It reaches the same conclusion as the clinical reviewer's review about Ms Harrison's clinical care.)

Background Information

HMP Eastwood Park

28. HMP Eastwood Park is a closed prison in Gloucestershire which holds up to 442 women. It has 10 residential wings, two of which specialise in dealing with prisoners with substance misuse issues. NHS England directly commissions Bristol Community Health Community Interest Company (BCH) to provide health care services. BCH provides primary care services and sub-contracts elements of health care services to other providers, working as a partnership called Inspire Better Health. This contract started in April 2016. Bristol Community Health provides clinical substance misuse services. Avon and Wiltshire Partnership NHS Trust provides mental health services. Healthcare is provided 24 hours a day.

HM Inspectorate of Prisons

29. The most recent inspection of HMP Eastwood Park was in May 2019. Inspectors reported that care and support for prisoners was good and reception and induction procedures were comprehensive. New arrivals had an initial health screen with a nurse, focusing on risks and immediate needs, including those relating to substance misuse withdrawal. Secondary health screenings were booked promptly, to identify and address prisoners' health needs immediately. Good liaison with community services helped to ensure continuity of care.

30. The need for drug and alcohol services was high and prisoners with substance misuse issues were managed on a dedicated unit. Eastwood Park had introduced a pregabalin reduction programme, which offered support to help prisoners to reduce their dependency gradually, ensuring that they were on clinically appropriate medication. Inspectors noted that health services were well integrated. The substance misuse strategy and management of medicines was robust and support had improved since the last inspection in 2016.

Independent Monitoring Board

31. 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 last published annual report, for the year to 31 October 2019, the Board said that in its opinion, Eastwood Park was a well-run prison where managers and staff treated prisoners with professionalism and care. The reception process was praised consistently by incoming prisoners who saw their overall initial experience at Eastwood Park in a very positive light.

32. The IMB noted that 48% of prisoners at Eastwood Park arrived with drug problems. It found that the prison tried very hard to provide a level of care that adequately and appropriately responded to those needs.

Previous deaths at HMP Eastwood Park

33. Ms Harrison was the fourth prisoner at Eastwood Park to die since November 2017. Of the previous deaths, two were from natural causes and one was drug-related. There are no similarities between our investigation findings in Ms Harrison's case and in the previous deaths.

Key Events

34. On 19 November 2019, Ms Joanne Harrison, also known as Ms Joanne Mutton, was remanded in custody charged with assault and possession of an offensive weapon, and sent to HMP Eastwood Park. She had been in prison before.

35. Ms Harrison arrived at Eastwood Park at 5.40pm. Her Person Escort Record (PER - a document that accompanies all prisoners when they move between police stations, courts and prisons that sets out the risks they pose) noted in the medical section that she had poor blood clotting due to alcohol misuse, that she had fits when withdrawing, had depression and had been sectioned under the Mental Health Act in August 2017. In the risk of harm section, it was noted that Ms Harrison had suicidal thoughts in July 2016, when she considered jumping off a bridge.

36. At 5.45pm, an officer recorded on Ms Harrison's prison record (NOMIS) that she had been admitted to Eastwood Park. An officer completed Mr Harrison's cell sharing risk assessment (CSRA). She noted that Ms Harrison had last been in prison custody in 1992 and that there were no alerts on her prison record. She assessed that Ms Harrison was a standard risk and a nurse noted on the CSRA that there was no medical information that increased Ms Harrison's risk.

37. All prisoners' telephone calls, except those that are legally privileged, are recorded, and prison staff listen to a random sample. The officer facilitated a telephone call and Ms Harrison spoke to her mother at 6.23pm for just under four minutes. She told her she was at Eastwood Park and due back in court on 12 December. Ms Harrison asked her next of kin to go to her property, check it was secure and collect her pet parrot. This was the only call Ms Harrison made while at Eastwood Park.

38. At 6.26pm, the officer completed the reception interview and recorded that she had not seen Ms Harrison's previous convictions. Ms Harrison told the officer she had self-harmed around ten years earlier, but had no current thoughts of suicide or self-harm. The officer recorded, 'I have explained the ACCT document to her and she stated she would speak to staff if struggling.'

39. At 6.31pm, a nurse completed Ms Harrison's initial healthscreen. She noted that Ms Harrison had an ulcer on her right leg, that she suffered from deep vein thrombosis (DVT), had alcohol related seizures, possible liver cirrhosis and asthma. Ms Harrison said that she attended Gloucestershire Drug and Alcohol Services, described herself as alcohol dependent, and that she was prescribed a daily 50ml dose of methadone (an opiate substitute). A urine test was positive for benzodiazepines, methadone and opiates. The nurse recorded that Ms Harrison's Clinical Institute Withdrawal Assessment for Alcohol (CIWA) score was 9 and her Clinical Opiate Withdrawal Score (COWS) score was 4, both indicators of mild withdrawal symptoms.

40. The nurse recorded that Ms Harrison had no thoughts of suicide or self-harm.

41. The nurse spoke to a prison GP for advice. At 7.06pm, the prison GP noted in Ms Harrison's medical record that she was opioid drug dependent, had alcohol

dependence syndrome and that the combination of Ms Harrison's medications placed her at high risk of overdose.

42. The prison GP noted that Ms Harrison was prescribed acamprosate (for alcohol withdrawal), chlordiazepoxide (for alcohol withdrawal / anxiety), metoclopramide (to prevent nausea vomiting), thiamine (B vitamin for alcohol misusers), dalteparin (for DVT), amitriptyline (for depression, anxiety & nerve pain), carbocisteine (to relieve COPD), co-codamol (for pain relief), mirtazapine (an antidepressant), omeprazole (to reduce stomach acid), pregabalin (for pain relief and/or anxiety), methadone (opiate substitute) and salbutamol (for asthma).

43. The prison GP noted the potential for liver toxicity of the medication Ms Harrison was taking. He recorded that pregabalin was to be reduced once Ms Harrison's medical history was known and he did not prescribe zopiclone (a sleeping pill), which had been prescribed to Ms Harrison in the community. He prescribed a 10ml dose of methadone until the prison could check Ms Harrison's prescription with the community pharmacist.

44. At 7.39pm, a nurse redressed the ulcer on Ms Harrison's leg. Ms Harrison was located on the Kinnon Unit, the drug and alcohol induction wing, in a single cell. The nurse told a nurse on Kinnon Unit that Ms Harrison's leg would need to be assessed again the next day.

45. Nurses checked on Ms Harrison every few hours during the night. They noted that she was either asleep or watching television.

20 November

46. On 20 November at 9.00am, a nurse completed Ms Harrison's second day healthscreen. She noted that Ms Harrison showed increased signs of withdrawal: she had mild to moderate tremors, was sweaty and had mild nausea. She revised her COWS to 5 and referred her for psychosocial intervention with the substance misuse team.

47. At 11.53am, a nurse noted that Ms Harrison was known to the community crisis team, had been sectioned under the Mental Health Act in 2017 and had been diagnosed with chronic depression. She referred Ms Harrison to the mental health team for assessment, and she was added to the waiting list.

48. At 3.23pm, a prison pharmacist established from the community pharmacist that Ms Harrison's methadone script was 50mls daily unsupervised. She told a prison substance misuse doctor, who prescribed Ms Harrison 50mls methadone a day, to be taken under supervision.

49. At 6.12pm, a nurse recorded in Ms Harrison's medical record that he saw Ms Harrison on the bench outside the medications hatch. He noted that a nurse told him that Ms Harrison appeared to be over-sedated, was struggling to stand up from the bench and was unable to hold her bowl and cutlery. The nurse noted that Ms Harrison went back to her cell to collect her identity card. He recorded that Ms Harrison was later seen by a nurse at the dining table, and that she still looked over-sedated. As a result, nurses and a prescriber from the substance misuse team agreed that Ms Harrison was not to be given her medication.

50. At 6.22pm, a nurse assessed Ms Harrison's leg ulcer. She noted the ulcer looked infected and advised Ms Harrison that she would have a doppler test (to measure blood flow) the next day and advised her to wear a compression stocking. She recorded that Ms Harrison did not have her methadone as she was over-sedated and that she was wobbly on her feet. She sent a task note to a prison GP at 6.26pm to advise her of this decision. She also noted that when she saw Ms Harrison at 4.00pm 'her presentation had been fine'.

51. A nurse noted that she observed Ms Harrison at 6.30pm, 7.00pm and 7.45pm and each time she was on her bed asleep, breathing normally. She recorded that she handed over the information to the night nurse.

52. At 8.04pm, a noted in Ms Harrison's medical record that she had confirmed her medications and she would start a pregabalin detox. Ms Harrison was observed throughout the night by a nurse who reported no issues. Ms Harrison slept throughout the night.

21 November

53. On 21 November at 10.20am, an officer carried out Ms Harrison's induction. (She recorded on Ms Harrison's prison record that a full induction was not required but said at interview this was incorrect and the full induction was delivered, although she may not have had a tour of the wing.) The officer recorded that Ms Harrison had signed all the prison compacts and was very talkative throughout the process. This was the last entry on Ms Harrison's prison record before she died.

54. At 11.45am, a recovery support worker completed a mental health assessment. She noted that Ms Harrison had been using sleeping tablets for many years (zopiclone) and was anxious that this medication had been stopped at Eastwood Park. Ms Harrison said she was still traumatised by the death of her son in 2012, and by abuse she had suffered in the past.

55. Ms Harrison disclosed that she had been sectioned in 2017, following a breakdown and several suicide attempts. Ms Harrison told recovery support worker that she 'doesn't feel great right now', but that she did not need mental health support, but wanted her medications reviewed. The recovery support worker recorded that there were no significant indicators of risk linked to suicide and self-harm, but referred Ms Harrison for bereavement counselling and to address her anxieties around sleep. At 2.31pm, an officer sent the outcome of her assessment to a prison GP and Ms Harrison was placed on the list to be discussed at the weekly multidisciplinary healthcare meeting on 25 November, with a view to her being managed by the primary care team (for those with mild to moderate mental health needs).

56. At 7.11pm, a nurse cleaned and redressed Ms Harrison's leg ulcer. A nurse started his night shift and observed Ms Harrison throughout the night. He recorded that she was asleep until 6.10am, when he saw her watching television.

22 November

57. At 10.46am, a nurse recorded in Ms Harrison's medical record that the referral to the primary care mental health team had been received and she had been referred for anxiety and sleep therapy and was waiting for an assessment with psychology.

58. At 1.31pm, a nurse recorded that she had tried to obtain a blood sample but could not do so because Ms Harrison was dehydrated. She also noted that she had seen Ms Harrison 'clearly intoxicated stumbling around her cell - instructed Joanne to lay down, which she did'. The nurse did not issue Ms Harrison's medication.

59. At 4.00pm, a nurse took Ms Harrison's observations. They were all within normal limits, although she had a fast pulse (106bpm). He recorded that Ms Harrison presented as 'normal' and was interacting with other prisoners on the unit. At 6.39pm, he recorded that Ms Harrison's observations were all within normal limits and he revised her COWS to 1, as she had no obvious signs of opiate withdrawal.

60. An operational support grade (OSG) carried out a roll check (count of prisoners) at around 8.20pm. The OSG said when he looked through Ms Harrison's observation panel, he saw her sitting slouched on a chair facing away from the door, and that she was asleep. He said he could not get a response from Ms Harrison but could see her breathing. he said that prisoners on Kinnon Unit often slept in very strange positions, sometimes even standing up, because they were detoxing. He said despite not being able to get a response, he had no concerns about Ms Harrison as this was not unusual behaviour from prisoners on the detox unit.

61. The OSG said that later that evening, though he could not remember the time, he looked through Ms Harrison's observation hatch and saw she was still asleep in the same position. He said he spoke to an officer for advice and they decided that because Ms Harrison could be seen breathing and was not being monitored under suicide and self-harm procedures (known as ACCT), there was no need to disturb her. The officer said the OSG told her that Ms Harrison was snoring. The OSG said when he checked this second time another prisoner shouted to him that Ms Harrison had had her medication, which would account for why she was asleep and not responding.

62. The night nurse on Kinnon Unit accessed Ms Harrison's medical record at 8.21pm, 10.56pm and 10.57pm, when checking her medications. She told the investigator that she went to see Ms Harrison to give her medication, but that, although she 'called her and called her', she could not get a response. She said she could see Ms Harrison's back, could see her breathing and just thought she was in a deep sleep and did not want to disturb her. However, she observed her through the observation hatch each time she went to check on other prisoners and she could see Ms Harrison was still breathing.

23 November

63. Closed Circuit Television (CCTV) shows that at 3.19am, the nurse went to Ms Harrison's cell and looked through the observation hatch and then returned a minute later. She was concerned that she could not see Ms Harrison breathing. She went downstairs and asked the OSG to return to the cell with her to check if Ms Harrison was breathing.

64. The nurse and OSG went back to Ms Harrison's cell at 3.22am. The OSG used the nurse's radio (his radio battery was flat) to ask an officer (the assistant night manager) to come to Kinnon Unit. The assistant night manager telephoned the wing office and spoke to an officer who said there were concerns about Ms Harrison.

65. At 3.23am, the OSG asked a Custodial Manager (CM), the night manager, for permission to break his sealed pouch so he could enter Ms Harrison's room. The CM told him to wait as he was on his way. At 3.24am, an officer arrived outside Ms Harrison's cell and the nurse used her radio to ask the emergency response nurse to come to Kinnon Unit.

66. At 3.26am the CM and two assistant night managers arrived at Ms Harrison's cell and the CM unlocked the door. The officer, the OSG and the nurse entered. The OSG said Ms Harrison was in the same position she was in when he completed his roll check at around 8.20pm. The nurse described Ms Harrison as sitting at her desk, not breathing and with no pulse.

67. At 3.27am, the CM asked for an ambulance to be called. The emergency response nurse arrived and entered the cell.

68. The nurse left to collect the emergency medical bag and defibrillator, while staff moved Ms Harrison to her bed. The emergency response nurse described Ms Harrison as a little cold, but that she was not stiff and had no obvious signs of blood pooling, so she started cardiopulmonary resuscitation (CPR). The nurse retuned at 3.28am and attached the defibrillator, which indicated there was no shockable rhythm. Staff continued CPR until paramedics arrived.

69. South West Ambulance Service records show they received a request for an ambulance at 3.27am. When paramedics arrived at 3.47am, they moved Ms Harrison to the landing outside her cell as there was more space. Paramedics continued CPR while they assessed Ms Harrison. They were unable to resuscitate her and at 4.10am, declared that she had died.

70. The nurse made a retrospective entry at 6.01am on Ms Harrison's medical records recording events. The nurse did not make an entry.

Contact with Ms Harrison's family

71. The prison appointed an officer as the prison family liaison officer (FLO) and a second officer as her deputy. Ms Harrison had nominated her partner, who was at HMP Hewell, as her next of kin. At 8.45am, the duty governor contacted Hewell and with the assistance of a prison chaplain informed Ms Harrison's partner of her death.

72. Ms Harrison's partner asked that he inform Ms Harrison's next of kin, which he did. The deputy FLO visited Ms Harrison's other next of kin and other family members at 12.45pm. They then travelled to Hewell to meet with Ms Harrison's partner.

73. The prison provided ongoing support to Ms Harrison's partner and family members, including facilitating a visit between Ms Harrison's partner and her family. The

prison contributed towards the costs of Ms Harrison's funeral, which was held on 20 December, in line with national policy.

Support for prisoners and staff

74. The duty governor debriefed the prison and healthcare staff involved in the emergency response and offered his support and that of the staff care team, who were also present. Staff said they felt well supported.

75. The prison posted notices informing prisoners of Ms Harrison's death, and offering support. Staff reviewed all prisoners assessed as at risk of suicide and self-harm, in case they had been adversely affected by Ms Harrison's death.

Information received after Ms Harrison's death

76. After Ms Harrison died, an anonymous note was submitted to security which said that a prisoner on the wing had traded 'Spice' paper (psychoactive substances (PS) sprayed onto paper) with Ms Harrison. Other intelligence received said that a different prisoner had given Ms Harrison amitriptyline (antidepressant) during exercise.

77. Other prisoners told the investigator during her initial visit that they suspected Ms Harrison had not been taking her methadone in the community and therefore the dose given to her at Eastwood Park was heavily sedating her. All the prisoners who spoke to the investigator said Ms Harrison was very white, appeared 'off her head' most of the time at Eastwood Park and that healthcare staff were too inexperienced to manage the situation. They thought that Ms Harrison had accidently overdosed and did not intend to harm herself.

Post-mortem report

78. The post-mortem examination showed no trauma to Ms Harrison's body to cause or contribute to death. It found that Ms Harrison had liver cirrhosis (scarring of the liver caused by long-term liver damage) but the other major organs showed no natural disease to account for death.

79. Toxicology results showed Ms Harrison had methadone, amitriptyline, codeine, paracetamol, desmethyldiazepam, chlordiazepoxide, nortriptyline, mirtazapine and pregabalin in her blood. There was no PS detected.

80. Methadone acts as a central nervous system depressant and the toxic effects include sedation, weakness, respiratory depression, coma and death. The pathologist noted that the level of methadone found in Ms Harrison's system could cause death in a person without tolerance to methadone, but that regular users of methadone may not experience effects. The level of amitriptyline found was at the lower end of the range of levels at which deaths have been attributed to amitriptyline toxicity. Amitriptyline taken in excess can result in coma, seizures, cardiac abnormalities and death.

81. The pathologist noted that there were several other medications present that have a depressive action in the brain and that although none of these were present in

excessive quantities, it was possible that these had combined with methadone and amitriptyline to cause 'over-sedation' and death.

82. The pathologist also noted that there is an increased risk of opioid toxicity and toxic effects from amitriptyline in individuals with liver cirrhosis.

83. She concluded that Ms Harrison died from methadone and amitriptyline toxicity, enhanced by other medication with a central depressant action in a woman with liver cirrhosis.

Findings

Clinical care

84. The clinical reviewer concluded that the clinical care Ms Harrison received at Eastwood Park was of a reasonable standard and was equivalent to that which she could have expected to receive in the community. However, he did identify some issues of concern with the management of her substance misuse.

Management of substance misuse and withdrawal symptoms

85. The clinical reviewer noted that when Ms Harrison arrived at Eastwood Park, the GP correctly identified that the combination of drugs she was taking could be potentially toxic in view of her liver cirrhosis, and very quickly stopped zopiclone and started a reduction programme for pregabalin.

86. The clinical reviewer was satisfied that it was appropriate not to consider reducing other central depressants (methadone and amitriptyline) at the same time, although he said that it would have been appropriate to start a slow reduction programme for these two drugs at a future date.

87. He found this aspect of the care Ms Harrison received from the GP was in accordance with good medical practice.

88. The GP started Ms Harrison on a methadone programme promptly and on an alcohol detoxification programme, with daily observations by clinical staff. However, the GP relied on nurses to report any concerns to him and did not arrange to review Ms Harrison himself. The clinical reviewer concluded that this was a concern, given the complexity of Ms Harrison's case (with comorbidities and a history of seizures during alcohol withdrawal).

89. There were two occasions when clinical staff noted that Ms Harrison appeared to be either 'over-sedated' or 'intoxicated'. On 20 November, she was seen struggling to get up from the bench outside the medications hatch and appeared 'over-sedated' later on at the dining table. Her methadone was withheld that evening. On 22 November, a nurse saw her stumbling around her cell and described her as 'clearly intoxicated'. Although she sent a computerised task note to the prison doctor there is no evidence an appointment for review was made.

90. The clinical reviewer noted that, although Ms Harrison was clinically observed until she recovered, there is no evidence healthcare staff considered if Ms Harrison had been using illicit drugs or alcohol or had obtained prescribed medication from another source, and sometimes only a visual assessment of her condition was made.

91. The clinical reviewer found it was a concern that healthcare staff did not refer Ms Harrison to the GP for a review after her medication was withheld. The Head of Healthcare said that the model of care at Eastwood Park transfers care from the GP at reception to a non-medical prescriber (NMP) for substance misuse, and that healthcare staff would not involve the GP unless there is 'considerable complexity

of health conditions'. She said that the NMP would have been scheduled to review Ms Harrison's record after five days "to amend the script'.

92. However, the clinical reviewer noted that NICE guidance (CG 115) states that a symptom-triggered approach should be adopted that involves tailoring the drug regimen according to the severity of withdrawal and any complications, and that the service user should be monitored on a regular basis. The clinical reviewer considered that a review at 5 days by a non-medical prescriber, when Ms Harrison had considerable complex co-morbidities, did not adhere to this guideline.

93. The clinical reviewer noted that, although Ms Harrison was monitored for alcohol withdrawal by staff on the unit on the second day of the regime (20 November) using the CIWA tool, there is no record that this was carried out on the following day (21 November). In addition, Ms Harrison had several significant medical conditions which would have made close medical supervision important during an alcohol detoxification programme, including known liver disease and a previous alcohol withdrawal epileptic seizure. She also appeared "over-sedated" on 20 November. The clinical reviewer considered that all of these issues should have prompted either an early routine review by the GP (or another suitably qualified health professional) much sooner than at five days,

94. We make the following recommendations:

The Head of Healthcare should review the policy on GPs conducting follow up visits for prisoners undergoing a detoxification programme.

The Head of Healthcare should ensure that healthcare staff:

- **complete full clinical observations when a prisoner on a detoxification programme appears over-sedated or intoxicated; and**
- **refer the prisoner to a GP.**

Mental health

95. The clinical reviewer noted that Ms Harrison was assessed promptly by mental health services and referred appropriately for bereavement counselling, anxiety management and sleep management groups. An appropriate decision had been made to manage her within primary care but there had not been time to confirm this at a multidisciplinary team meeting before her death.

Communication with prison staff

96. We are concerned that, when healthcare staff considered that Ms Harrison was 'over-sedated' or 'intoxicated', there is no evidence that they shared their concerns with prison staff, either in person or by making a note in the wing observations book.

97. If prison staff had known about these concerns, they may have sought assistance sooner when Ms Harrison was asleep and unresponsive on the evening of 22 November. (We note that, although they were working on a detox unit, neither the

OSG or the second officer, were aware that heavy snoring can be a sign of a drug overdose.)

98. We are also concerned that healthcare staff did not submit intelligence reports about these concerns, even though they may have suggested that Ms Harrison was obtaining illicit drugs and/or alcohol in the unit.

99. A nurse said that, without access to NOMIS, healthcare staff are reliant on asking prison officers to log onto the prison system to complete intelligence reports, and they are sometimes not submitted. However, there is no evidence in Ms Harrison's case that healthcare staff did ask prison staff to complete reports.

100. We recommend:

The Governor and Head of Healthcare should ensure that healthcare staff have improved access to NOMIS.

The Head of Healthcare should ensure that:

- **healthcare staff tell prison staff if a prisoner on a detoxification programme appears over-sedated or intoxicated;**
- **record that they have done so in the prisoner's medical record; and**
- **complete an intelligence report.**

Emergency Response

Communicating the emergency

101. PSI 03/2013, *Medical Emergency Response Codes*, says that all prisons must have a medical emergency response code protocol so that staff can clearly and concisely convey the nature of the medical emergency. It says that where a prisoner is found unresponsive, staff should call an emergency code blue and the control room should telephone for an ambulance immediately.

102. When the night nurse checked Ms Harrison at around 3.19am and could not see her breathing, she asked the OSG to go to the cell with her. When they got there at 3.22am and neither could see her breathing, the OSG used the nurse's radio to request assistance. (The OSG's radio battery had gone flat. He said he did not hear any sound from his radio to alert him to the fact his battery had died.) Shortly after, he asked the CM for permission to enter Ms Harrison's cell, but was told to wait. The nurse also radioed the emergency healthcare responder and asked her to come to the unit.

103. Neither the nurse nor the OSG called a code blue medical emergency. The emergency response nurse responded to the request to attend Kinnon Unit, but did not collect the emergency medical bag, as she said she did not realise it was a medical emergency. The CM said if he had heard a code blue, he would have told the OSG to enter Ms Harrison's cell immediately. Both the emergency response nurse and the CM also said they were not told that Ms Harrison was not breathing.

104. The night nurse said she did not call an emergency code over her radio as she wanted to be certain of the situation. The OSG said he also wanted to be 100% sure of the situation, but said in hindsight he would use a medical emergency code if a similar situation arose.

105. There was a delay of around eight minutes from when the nurse first had concerns that Ms Harrison was not breathing, until an ambulance was requested. It is unlikely that the delay affected the outcome in Ms Harrison's case, but we know that in an emergency situation a delay of a few minutes could be critical.

106. After Ms Harrison's death, Eastwood Park identified that the correct medical emergency protocol had not been followed and reissued a Notice to Staff (NTS 162/2019) on 25 November, setting out the correct guidance. As action has already been taken, we make no general recommendation on this issue. However, we recommend that:

The Head of Healthcare should share this report with the nurse who was on night duty on Kinnon Unit on 22/23 November and discuss the Ombudsman's findings with her.

107. We are also concerned that the OSG's radio was not working and make the following recommendation:

The Governor should ensure that arrangements are in place to enable officers to replace or recharge radio batteries before their shift ends, including at night.

Entering Ms Harrison's cell

108. PSI 24/2011, *Management and Security at Night*, says that staff have a duty of care to prisoners, to themselves and to other staff. The preservation of life must take precedence over the usual arrangements for opening cells and where there is, or appears to be, immediate danger to life, cells may be unlocked without the authority of the night orderly officer and an individual member of staff can enter the cell on their own. Staff are not expected to take action that they feel would put themselves or others in unnecessary danger. What they observe and any knowledge of the prisoner should be used to make a rapid dynamic risk assessment.

109. Officers do not carry cell keys on their key chains at night but have a key in a sealed pouch for use in an emergency. The OSG said that, in his experience, he was told to wait to enter a cell until other staff who were C&R (control and restraint) trained were present for security reasons, as it could be that a prisoner is feigning illness/injury and might attack staff. The OSG was unaware until after Ms Harrison's death that if there is a potentially life-threatening situation, he had the authority to make the decision to break his sealed pouch and enter a cell.

110. We are concerned that the CM did not ask the OSG questions about why he wanted to enter Ms Harrison's cell. If he had been told that Ms Harrison did not appear to be breathing, we consider that he should have told the OSG to enter the cell if he considered it safe to do so, and should not have told him to wait until he arrived. He should also have told him to call a code blue.

111. Waiting for the CM to arrive caused a delay of a couple of minutes before staff entered the cell and began providing medical assistance. Although this probably did not affect the outcome for Ms Harrison, it could make a critical difference in other emergency situations.

112. We make the following recommendations:

The Governor and Head of Healthcare should ensure that staff enter a prisoner's cell immediately in a medical emergency, where it is safe to do so.

The Governor should ensure that night orderly officers understand that, in a medical emergency, staff do not need to seek their permission or wait for them to arrive before they enter the cell.

The Governor should share this report with the OSG who was on night duty on Kinnon Unit on 22/23 November and with the CM who was night manager and arrange for a senior manager to discuss the Ombudsman's findings with them.

Body-worn video cameras

113. None of the officer's present when Ms Harrison was discovered used a body-worn video camera (BWVC). PSI 04/2017, *Body Worn Video Cameras*, states it is mandatory for staff to use BWVCs at any reportable incident (as outlined in PSI 11/2012, Management and Security of the Incident Reporting System) and that staff should start recording at the earliest opportunity to maximise the material captured by the camera.

114. The CM said he did not recall if he was wearing a camera, but that it was not a current requirement to wear one at night. The CM said he was unsure if it would have been appropriate or decent to activate a camera in such circumstances as Ms Harrison's. An officer said she had never worn a camera during a night shift and understood that wearing a camera at any time was personal choice, but that she usually wore one during the day. In this case, it appears that none of the officers were wearing a BWVC. We are concerned that not requiring staff at Eastwood Park to wear a BWVC at night is not compliant with PSI 04/2017, which says that staff must use BWVCs at any reportable incident. We make the following recommendation:

The Governor should ensure that sufficient numbers of staff are assigned to wear BWVCs, on day and night shifts, and that they activate them at the earliest opportunity during any reportable incident.

Reception procedures – assessment of risk of suicide and self-harm

115. There is no evidence to suggest that Ms Harrison intended to take her life. There was also no indication that she was at increased risk of suicide and self-harm while at Eastwood Park. Nevertheless, there were failings with the reception screening process, which we consider we should highlight.

116. Prison Service Instruction (PSI) 07/2015, *Early Days in Custody*, says that reception staff must identify prisoners who might be at risk of suicide and self-harm and manage them appropriately. The PER and any other available documentation must be examined in reception to assess the prisoner's risk of suicide and self-harm. PSI 64/2011, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody)*, states that, after speaking to a prisoner, staff should use their judgement in combination with all available evidence to inform their decision as to whether a prisoner poses a risk to themselves. Both instructions list several risk factors and triggers that might increase a prisoner's risk of suicide and self-harm.

117. A nurse said that although PER forms were available to reception nurses completing the initial health screen, they did not always look at them. The nurse and other nurses the investigator interviewed, were unaware of the information contained in PSIs about potential risks and triggers for new receptions.

118. The Head of Healthcare told the investigator that PER forms did not always arrive with prisoners and those that did were not always available to healthcare staff, and that she had previously raised this issue with the local Quality and Delivery Board. However, the head of healthcare contacted the investigator in January 2020, to say after a further investigation she has been reassured that PER forms are available to healthcare staff, and that her initial comments were incorrect.

119. Ms Harrison was not monitored under suicide and self-harm procedures (known as ACCT) during her time at Eastwood Park. Healthcare staff assessed that her mental state was stable and Ms Harrison consistently said she had no thoughts of suicide or self-harm. An officer who completed the reception interview also assessed there were no risk factors necessitating ACCT procedures to be started.

120. However, the head of healthcare said when she reviewed Ms Harrison's medical file she identified that ACCT procedures should have been started when Ms Harrison arrived at Eastwood Park, as Ms Harrison had a history of attempted suicide. The head of healthcare provided the investigator with a copy of Inspire Better Health's *Improving sharing of information in Assessment, Care in Custody and Teamwork (ACCT) documents – prisons workbook*, dated 2018. This workbook, given to all healthcare staff to supplement formal prison training, states:

> 'If an offender shares that they have self-harmed in the past, an ACCT must be opened. We do not apply clinical judgement in this process.'

121. The Head of Healthcare said the healthcare providers, Bristol Community Health and Avon and Wiltshire Partnership Trust, had received a Prevention of Future Deaths Report from the Coroner following an inquest into a death at a different prison in the area. Because of this, the Head of Offender Healthcare, required all healthcare staff to no longer use clinical judgment, but to start ACCT procedures on all prisoners with any history of suicide attempts or self-harm, irrespective of the length of time that had passed. The Head of Healthcare said as a direct result there had been an increase in the number of ACCTs at Eastwood Park, which the prison has had to try and manage.

122. We found that healthcare staff at Eastwood Park did not follow their own guidance outlined in Inspire Better Health's *Improving sharing of information in Assessment, Care in Custody and Teamwork (ACCT) documents*. However, we are concerned

that starting ACCT procedures for every individual who has self-harmed in the past, regardless of how long ago, is an ineffective use of ACCT procedures. The routine or overuse of ACCT procedures could lead to increased workload, dilute the process and divert resources from those who genuinely require support. We consider that the decision on whether to start ACCT procedures should be based on all the evidence available and an assessment by staff. Staff also need to record the reasons for their decision and the factors they have taken into account. We make the following recommendations:

The Head of Healthcare should revise the guidance contained in *Improving sharing of information in Assessment, Care in Custody and Teamwork (ACCT) documents – prisons workbook* to bring it into line with national guidance in PSIs 07/2015 and 64/2011 on when ACCT procedures should be started.

The Governor and Head of Healthcare should produce clear guidance about procedures for identifying prisoners at risk of suicide and self-harm. In particular, this should ensure that reception, healthcare, first night staff and all others who assess risk:

- **have a clear understanding of their responsibilities and the need to share all relevant information about risk;**
- **consider and record all known risk factors of a newly-arrived prisoner when determining their risk of suicide and self-harm, including information from the Person Escort Record (PER) and other sources; and**
- **document the information considered and the reasons for the decision on whether or not to start ACCT procedures.**

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