Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Jacqueline Purnell, a prisoner at HMP/YOI East Sutton Park, on 24 December 2021

A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T l 020 7633 4100

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

Summary

1. 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.

2. We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

3. Ms Jacqueline Purnell died on 24 December 2021 of a heart attack at HMP East Sutton Park. Ms Purnell was 59 years old. I offer my condolences to Ms Purnell's family and friends.

4. The clinical reviewer concluded that the clinical care Ms Purnell received at East Sutton Park was equivalent to that she could have expected to receive in the community. He made two recommendations which did not contribute to the circumstances of Ms Purnell's death and so are not repeated here but will need to be addressed by the Head of Healthcare.

5. We found no non-clinical issues of concern. We make no recommendations.

The Investigation Process

6. NHS England commissioned an independent clinical reviewer, to review Ms Purnell's clinical care at East Sutton Park. The clinical reviewer's report is attached as Annex 1.

7. The PPO investigator has investigated non-clinical issues, including Ms Purnell's location, the emergency response and liaison with her family.

8. The PPO family liaison officer wrote to Ms Purnell's next of kin, to explain the investigation. They had questions about whether Ms Purnell received ongoing appointments for her underlying health conditions. We have addressed these questions in separate correspondence.

9. Ms Purnell's family received a copy of the draft report. They raised a number of questions that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

10. 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.

Previous deaths at HMP East Sutton Park

11. Ms Purnell was the only prisoner to die at East Sutton Park in the last two years.

Key Events

12. On 23 March 2018, Ms Jacqueline Purnell was sentenced for possession with intent to supply drugs and was sent to HMP Bronzefield. At her initial health screens, healthcare staff noted that she had asthma, diabetes, cardiac issues, high blood pressure, was overweight and a smoker and had suffered a heart attack in 2013.

13. On 26 March 2020, Ms Purnell transferred to HMP East Sutton Park.

14. On 16 October, Ms Purnell was prescribed a spray used to treat angina (chest pains caused by a reduced flow of blood to the heart) and was told that if the chest pain did not ease after five minutes, an ambulance should be called. A week later, on 23 October, a prison GP referred Ms Purnell to the hospital's vascular department. On 26 January 2021, the hospital rearranged Ms Purnell's appointment to 10 February due to Covid-19. Ms Purnell was sent an appointment slip asking her to attend healthcare for her telephone appointment. On 24 February, East Sutton Park received a letter from the hospital saying that Ms Purnell had been given three telephone appointments, but she had not attended and that she would be given a face to face appointment in due course.

15. On 26 April 2021, healthcare staff drew up a care plan to manage Ms Purnell's diabetes and high blood pressure, to be reviewed in six months' time. Ms Purnell had her blood test reviewed and was referred for lifestyle advice. Healthcare staff did not draw up a care plan for Ms Purnell's heart disease.

16. On 13 May, Ms Purnell had an asthma review and did not want to be referred to a support service to stop smoking.

24 December 2021

17. At 2.36am, a prisoner contacted the prison's centre office using the radio in the communal kitchen to say that Ms Purnell was suffering with chest pain and pain in her left arm. Two officers went to Ms Purnell and took a defibrillator. At 2.38am, an OSG called an ambulance from the centre office.

18. Around 2.46am, Ms Purnell became unresponsive and officers started CPR. The OSG updated the ambulance service over the phone, who upgraded the priority of the emergency.

19. At 3.01am, the ambulance arrived. Paramedics took over treatment. At 3.43am, paramedics confirmed that Ms Purnell had died.

Post-mortem report

20. The post-mortem report concluded that Ms Purnell died of a heart attack caused by clogged arteries. She also had high blood pressure, which did not cause but contributed to her death.

Tallulah Frankland **June 2022**
Assistant Ombudsman

Prisons & Probation Ombudsman
Independent Investigations

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T l 020 7633 4100