

**Prisons &
Probation**

Ombudsman
Independent Investigations

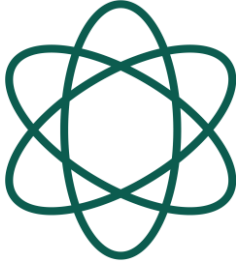
Independent investigation into the death of Ms Louise Cox, a prisoner at HMP/YOI Downview, on 20 May 2022

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

OGI

© Crown copyright, 2023

This report is licensed under the terms of the Open Government Licence v3.0. To view this licence, visit nationalarchives.gov.uk/doc/open-government-licence/version/3

Where we have identified any third-party copyright information you will need to obtain permission from the copyright holders concerned.

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 Louise Cox died of heart disease on 20 May 2022 at HMP Downview. She was 54 years old. I offer my condolences to Ms Cox's family and friends.

The events of 20 May were distressing for everyone involved. I was impressed with the emergency response from staff, who supported Ms Cox in very difficult circumstances before paramedics arrived. However, I found some concerning omissions in basic regime requirements that would have improved the process and supported staff. Two of the three defibrillators used during the response were faulty. There was no system for checking them regularly, to ensure they were usable in the event of an emergency. I was also concerned to find that staff did not know the location of defibrillators in parts of the prison that they did not work in, which created a delay in locating the third device when it was needed. Finally, I found that none of the staff on shift that night had up to date first aid training.

While we found no evidence that these factors impacted on the outcome for Ms Cox, they are unacceptable oversights that might impact on future outcomes. Prison managers have rightly addressed the learning as a matter of urgency and before our investigation concluded.

Overall, the clinical reviewer found that the clinical care provided to Ms Cox at Downview was equivalent to that which she could have expected to have receive in the community. However, she found a number of issues with clinical process and makes recommendations to the Head of Healthcare to address these.

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

Kimberley Bingham
Acting Prisons and Probation Ombudsman

March 2023

Contents

Summary	1
The Investigation Process.....	1
Background Information.....	4
Key Events.....	5
Findings	8

Summary

Events

1. On 25 May 2021, Ms Cox transferred to HMP Downview from HMP Peterborough. Healthcare staff completed an initial healthcare screening and recorded that Ms Cox had a range of health needs including suspected hypertension (high blood pressure) and bundle branch block (BBB - a condition which affects the heartbeat). Ms Cox also had a diagnosed personality disorder, for which she was prescribed psychotropic medication.
2. During her time at Downview, Ms Cox had three electrocardiograms (ECG - a test for the heart's rhythm) to monitor her BBB. The ECGs showed an abnormal heartbeat. Ms Cox's psychotropic medication had some cardiac side effects, so the prison psychiatrist reduced the prescription to minimise these.
3. On 11 June 2021, 18 July 2021 and 12 May 2022, Ms Cox told healthcare staff that she had chest pain and was short of breath. They referred Ms Cox to the hospital cardiology department, encouraged her to use her inhalers and altered her medication.
4. On 16 May, Ms Cox told another prisoner that she was breathless. The prisoner told her to see the nurse, but Ms Cox did not want to.
5. On 19 May, Ms Cox went to the prisoner's room and was out of breath again. The prisoner offered to speak to a nurse on her behalf, but she declined. The prisoner let Ms Cox use her salbutamol nebuliser (a machine which is used to relieve the symptoms of asthma and provides medication at a higher dose than an inhaler).
6. At 9.18pm on 20 May 2022, Ms Cox rang her cell bell and told an Officer Support Grade (OSG) that she could not breathe. The OSG called a code blue (a call over the radio communicating that a prisoner is struggling to breathe). Officers attended and called an ambulance. Ms Cox lost consciousness and staff started CPR. They found that the first two defibrillators they applied did not work. The third defibrillator did work and gave them instructions to continue with CPR.
7. Paramedics arrived at 9.38pm and at 11.07pm they pronounced that Ms Cox had died.

Findings

8. The clinical reviewer concluded that the care Ms Cox received was equivalent to that which she could have expected to receive in the community, however there was a need for improved clinical practice at Downview. She identified issues with healthcare's response to Ms Cox's ECG results and the management of her long-term health conditions.
9. Staff involved in the emergency response reported two issues with the defibrillators. Firstly, the first two defibrillators collected by officers did not function properly. This meant that staff were delayed in getting instructions on how to care for Ms Cox. Secondly, staff reported that they only knew the locations of the defibrillators in the

parts of the prison that they worked in. This led to delays in locating a third defibrillator. After Ms Cox's death, a governor conducted an audit and replaced the faulty defibrillators. He installed two new defibrillators in areas where there was no coverage. The business hub now checks the defibrillators on a weekly basis and signs have been erected to direct staff to the nearest devices.

10. On 20 May 2022, none of the staff on site had up to date first aid training. This meant that when Ms Cox was struggling to breathe, the first aid cover required by Prison Service Instruction (PSI) 29/2015: First Aid, was not available. Managers at Downview have now sent all senior officers on first aid training courses and have satisfied themselves that they have sufficient cover during the night shift.
11. The events of 20 May were distressing for everyone involved. Despite this and the lack of up-to-date training, staff worked extremely hard through very challenging circumstances to try and keep Ms Cox alive until paramedics arrived.
12. After Ms Cox's death, a governor told us that she spoke to staff involved in the emergency response individually to de-brief, offer support and relieve from work. She recorded notes on each of the conversations. When interviewed, one member of staff remembered speaking to the governor and others reported that they either did not remember whether a manager had spoken to them or said that no one did. They also reported that they felt prison managers' response to the Ms Cox's death was slow and that they had been asked to do tasks that managers should have completed. We found no evidence of policy compliance issues and are unable to verify whether the de-briefs took place. However, we think it would be helpful for the management team to revisit local protocols for deaths in custody, in consultation with staff, to ensure that expectations are understood and adhered to. We bring this suggestion to the Governing Governor's attention.

Recommendations

- The Governor should share this report with Officers A and B, the OSG, the SO and any other staff who were involved in the emergency response on 20 May and pass on the PPO's recognition of their efforts.

The Investigation Process

13. The investigator issued notices to staff and prisoners at HMP Downview informing them of the investigation and asking anyone with relevant information to contact her. Ms Cox's friend and fellow prisoner contacted the investigator to inform her of Ms Cox's health in the week before she died.
14. The investigator obtained copies of relevant extracts from Ms Cox's prison and medical records.
15. The investigator interviewed four members of staff and one prisoner at Downview on 31 August and 7 September 2022.
16. NHS England commissioned a clinical reviewer to review Ms Cox's clinical care at the prison. The clinical reviewer and the investigator jointly interviewed two members of staff.
17. We informed HM Coroner for Surrey of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.
18. The Ombudsman's family liaison officer contacted Ms Cox's next of kin, to explain the investigation and to ask if they had any matters they wanted us to consider. They shared their concerns about Ms Cox's health in the weeks leading up to her death and the standard of care she received while at HMP Peterborough. Their concerns have been addressed below or in separate correspondence.
19. Ms Cox's next of kin received a copy of the draft report. They raised a question that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.
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.

Background Information

HMP Downview

21. HMP Downview is a closed women's prison which holds up to 365 women. Healthcare is provided by Central and Northwest London NHS Foundation Trust between 7.15am and 6.15pm Monday – Friday and between 8.00am and 5.30pm at weekends.

HM Inspectorate of Prisons

22. The most recent inspection of HMP Downview was in July 2021. Inspectors reported that safety was reasonably good, and that healthcare provision was generally very good.
23. They found that emergency response equipment owned by healthcare was checked and appropriately maintained (this does not include the defibrillators mentioned in this report, which are owned and maintained by the prison management team). Women requesting urgent GP appointments were seen in a timely manner and women making routine requests were placed on the waiting list, which was up to three weeks long. Long-term conditions oversight was weak, and of the 16 patient records reviewed, only three women had an up-to-date care plan.

Independent Monitoring Board

24. 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 2020 to 2021, the IMB reported that Downview was a safe prison that met prisoners' primary healthcare needs.

Previous deaths at HMP Downview

25. Ms Cox was the first prisoner to die at Downview since May 2020.

Key Events

26. On 16 May 2013, Ms Louise Cox was given a life sentence.
27. On 25 May 2021, she was transferred from HMP Peterborough to HMP Downview. Healthcare staff completed an initial healthcare screening and recorded that Ms Cox had suspected hypertension (high blood pressure), depression and anxiety. She was also overweight and an ex-smoker who used an e-cigarette. Ms Cox also reported that she had a history of bundle branch block (a condition which effects the heartbeat) and healthcare at Peterborough had made a referral to a cardiologist (a doctor who specialises in heart defects and disease).
28. Ms Cox had a diagnosed borderline personality disorder for which she had been prescribed psychotropic medication.
29. On 1 June 2021, Ms Cox saw the prison GP, who prescribed inhalers and added her to the waiting list for an asthma review.
30. On 11 June, a prison GP reviewed Ms Cox after she reported chest pain and swollen ankles. The GP changed her blood pressure medication and made a referral to a cardiologist. On 25 June Ms Cox attended a further GP review. The GP noted that the swelling in her ankles had reduced, but her blood pressure had increased. They prescribed a new blood pressure medication.
31. On 28 June, Ms Cox had an ECG (a test which checks the heart's rhythm), which confirmed Ms Cox's bundle branch block. The prison GP saved the results on Ms Cox's record but took no further action.
32. On 18 July, Ms Cox told healthcare staff that she had chest pain and a cough. Healthcare staff advised her how to use her inhalers properly and how to use her glyceryl trinitrate spray (an oral spray which helps to relieve chest pain).
33. On 19 July, the prison GP reviewed Ms Cox, who reported that her chest pain had gone but her sore throat remained. The GP noted that Ms Cox's observations were good but that there was some wheezing in her chest. They strongly advised that Ms Cox change her pain-relief medication because of its cardiac side effects. Ms Cox declined the offer and accepted the risks. The GP wrote an alert on Ms Cox's medical record that there was a high risk of heart complications and staff should call an ambulance if she had any chest pain. He also prescribed antibiotics.
34. On 19 December, Ms Cox attended a hospital cardiology appointment. The cardiologist noted that Ms Cox had attended A&E for prolonged chest pain one year prior. An ECG showed an abnormal heartbeat, so the cardiologist arranged further tests.
35. On 3 February 2022, Ms Cox told her keyworker that she had experienced a mild ache in her chest, but it had disappeared. Her keyworker encouraged her to go to healthcare, but we found nothing in her medical record to suggest that she did.
36. On 17 February, the prison psychiatrist completed a review of Ms Cox's mental health. They altered her psychotropic medication due to the cardiac side effects.

37. On 7 April, healthcare staff reviewed Ms Cox's asthma and created an asthma care plan. They had no concerns about Ms Cox's asthma management.
38. On 13 April Ms Cox attended a hospital appointment for a heart scan. The results of the scan were not provided to Ms Cox when she was transferred back to Downview and were not recorded in her medical notes.
39. On 12 May, the prison psychiatrist held a review with Ms Cox and requested an ECG because she had not had one for a while. Ms Cox stated that she was struggling to sleep and waking up short of breath. The psychiatrist told Ms Cox to speak to the prison GP.
40. On 16 May, Ms Cox told a prisoner that she was breathless. The prisoner told Ms Cox to see the nurse, but Ms Cox did not want to.
41. On 17 May, Ms Cox had an ECG. Like the previous occasion, the results were not provided to her or reflected in her medical notes.
42. On 19 May, Ms Cox went to the prisoner's room and was out of breath. The prisoner offered to speak to a nurse for Ms Cox, but Ms Cox said no. The prisoner let Ms Cox use her salbutamol nebuliser (a machine which is used to relieve the symptoms of asthma and gives the medication at a higher dose than an inhaler). She let her use this medication because Ms Cox was also prescribed salbutamol, in inhaler form. Ms Cox's symptoms improved after using the salbutamol nebuliser.
43. On 19 May, Ms Cox was booked to have an ECG (as requested by the psychiatrist on 12 May), but the ECG machine was broken, and healthcare cancelled her appointment.

Events of 20 May 2022

44. At approximately 8.00pm on 20 May, an Officer Support Grade (OSG) looked into Ms Cox's cell and saw her lying on her bed watching television. Ms Cox wished the OSG good night.
45. At approximately 9.18pm, Ms Cox called her cell bell and said that she could not breathe. The OSG responded, and when she saw that Ms Cox was struggling to breathe, she asked her to sit on her bed and take deep breaths. She called a code blue (a call over the radio communicating that a prisoner is struggling to breathe) and two officers responded.
46. When both officers entered Ms Cox's cell, they could see that she was distressed and struggling to breathe. Officer A radioed for an ambulance to be called. The officers encouraged Ms Cox to take deep breaths and use her inhaler, but she slumped to the floor. Officer A put Ms Cox into the recovery position, but her face started to change in colour. Officer A noted signs that Ms Cox was not breathing and started CPR. A Senior Officer arrived at the cell soon after.
47. Around 9.25pm Officer A left Ms Cox's cell to find the defibrillator in the nearby C wing office. On application, the officers found that the defibrillator was faulty. Officer A left the cell to run to the D wing office. On application, the officers found that this defibrillator was also faulty.

48. At approximately 9.30pm, Officer A left the cell again to retrieve a third defibrillator from B wing. An OSG offered to assist but could not find the defibrillator on B wing so went to A wing.
49. At approximately 9.35pm, Officer A arrived back at Ms Cox's cell with the defibrillator from A wing. This defibrillator worked and advised that there was no shockable rhythm and to continue with CPR.
50. At 9.38pm, paramedics arrived and took over from the staff.
51. At 11.07pm, paramedics confirmed that Ms Cox had died.

Contact with Ms Cox's family

52. Downview appointed a family liaison officer, who informed Ms Cox's next of kin of Ms Cox's death the following morning and offered ongoing support.
53. Downview offered to contribute to Ms Cox's funeral costs in line with national policy.

Support for prisoners and staff

54. After Ms Cox's death, a governor spoke to the staff involved in the emergency response individually. She asked staff if they needed to finish their shifts early. She recorded notes of the conversations and provided these to the investigator. The staff care team also offered support.
55. The prison posted notices informing other prisoners and other staff of Ms Cox's death and offering support.

Post-mortem report

56. The post-mortem report concluded that Ms Cox died of a heart disease. Hypertension (high blood pressure) was a contributing factor in Ms Cox's death.

Findings

57. The clinical reviewer concluded that the care Ms Cox received was equivalent to that which she could have expected to receive in the community, however there was a need for improved clinical practice. The clinical reviewer was concerned that healthcare staff did not take sufficient action in response to Ms Cox's ECG results, particularly considering her medication had cardiac side effects.
58. The clinical reviewer was concerned that Ms Cox did not have an asthma review until 11 months after her transfer to Downview, and that staff did not record that she was not collecting her inhaler prescriptions at her asthma review on 7 April 2022.
59. The clinical reviewer noted that attempts to manage Ms Cox's weight were done through the prescribing of medicine and no wider weight management programme was used. The healthcare team confirmed that dietary and exercise advice would have been given to Ms Cox, but we found no record of this in her medical records.

Emergency Response

Defibrillators

60. At the time of Ms Cox's death, Downview had 14 defibrillators installed across the prison. The two defibrillators closest to Ms Cox's cell were faulty. This meant that staff were delayed in being instructed on how to care for Ms Cox. The issues with the defibrillators also created distress for the staff involved in the emergency response and the prisoners who could hear what was going on from their cells.
61. Staff also reported that they only knew the locations of the defibrillators in the parts of the prison that they worked in. This created a delay when staff went to retrieve a third device.
62. A governor was tasked with auditing the defibrillators across the prison in October 2021. He found that three of the defibrillators had flat batteries and that the pads on all of the defibrillators were out of date. At this point, the defibrillators were four years old. He fixed the issues at the time but did not carry out any further checks. His rationale for not checking the defibrillators regularly was an information sheet he had seen onsite which detailed that defibrillators would remain functional for ten years. He took this piece of information to mean that they did not require further maintenance until 2027, despite his audit in 2021 revealing low batteries on defibrillators that were four years old.
63. After Ms Cox's death, the governor conducted another audit and replaced the faulty defibrillators, as well as installing two new defibrillators in areas where there was no coverage. The business hub now checks the defibrillators on a weekly basis and more signs have been erected that point staff to the nearest defibrillator.
64. The lack of defibrillator maintenance is very concerning, particularly in a prison without 24-hour healthcare and the support of medical professionals at all times. We are unable to measure the impact of this delay on the outcome for Ms Cox. We note that the faulty devices have now been replaced and the prison has

implemented a system that ensures any functionality problems are picked up and can be acted on. We spoke to the new Governing Governor, who joined the prison since Ms Cox's death. She recognised the significance of the issues we have found. We make no recommendation.

First aid

65. PSI 29/2015: *First Aid* requires prison managers to ensure that there is a sufficient number of 'emergency first aid at work' trained staff to provide emergency first aid to staff, prisoners and others at any given time. It states that the number will be determined by the local first aid risk assessment. The PSI strongly recommends that first-aiders undertake annual refresher training during any three-year certification period.
66. On 20 May 2022, none of the staff on site had up to date first aid training. This meant that there was not sufficient first aid cover on 20 May and is therefore a breach of PSI 29/2015.
67. Managers at Downview have now sent all custodial managers for first aid training and have satisfied themselves that they have sufficient cover during the night shift. We make no recommendation.

Staff Response

68. The events of 20 May were distressing for everyone involved. Despite training gaps and issues with the defibrillators, staff worked hard through very challenging circumstances to try and keep Ms Cox alive until paramedics arrived. They should be recognised for this. We make the following recommendation:

The Governor should share this report with Officers A and B, the OSG, the SO and any other staff who were involved in the emergency response on 20 May and pass on the PPO's recognition of their efforts.

Response to a death in custody

69. After Ms Cox's death, a governor spoke to staff members individually to ask for their experiences and any initial issues, as well as offering to release them from work. She recorded who she spoke to and what they said. When interviewed, one staff member remembered speaking to the Governor. The others reported that they either did not remember whether a prison manager spoke to them or categorically said no prison managers spoke to them. Staff also reported that they felt prison managers' response to the incident was slow and they had to complete tasks which should have been done by managers, for example, informing the police.
70. We recognise that deaths are relatively rare at Downview and across the wider women's prison estate. We saw no evidence of policy compliance issues, but the feedback we received suggests a lack of familiarity with the processes that follow a death in custody and that staff at all levels would benefit from clarity on these. We bring this to the Governing Governor's attention and would encourage prison managers to revisit local processes and remind staff at all levels of the expectations, including liaison with other agencies and staff support.

Inquest

71. The inquest into Ms Cox's death concluded on 9 June 2023, with a verdict of natural causes.

**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 | 020 7633 4100