Prisons & Probation Ombudsman
Independent Investigations

# Independent investigation into the death of Ms Georgina Henshaw, a prisoner at HMP Foston Hall, on 31 August 2018

**A report by the Prisons and Probation Ombudsman**

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

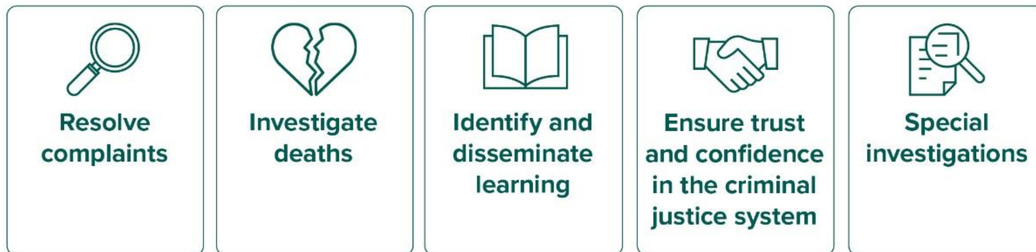
Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T I 020 7633 4100

## OUR VISION

**To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.**

## WHAT WE DO




## WHAT WE VALUE

**© 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 I oversee can improve their work in the future.

Ms Georgina Henshaw died on 31 August 2018 in her cell at HMP Foston Hall. The post-mortem was unable to provide a conclusive cause of death. Ms Henshaw was 37 years old. I offer my condolences to Mrs Henshaw's family and friends.

I find that some of the clinical care Ms Henshaw received at Foston Hall fell below the level she could have expected in the community. Although her prescribed medication posed a risk of cardiac problems, staff did not ensure that she attended for the necessary reviews and checks.

I am concerned that a nurse who attended the emergency response did not have the appropriate life support training.

I am also concerned that the post-mortem raised concerns that an airway device may have been inserted incorrectly during the resuscitation attempt and that this may have contributed to Ms Henshaw's death.

The prison also informed Ms Henshaw's family of her death by telephone, despite Prison Service Instructions making it clear that this should be done in person.

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** **October 2019**

# Contents

Summary ..... 1

The Investigation Process ..... 3

Background Information ..... 4

Key Events ..... 5

Findings ..... 12

# Summary

## Events

1. On 10 July 2017, Ms Georgina Henshaw was charged with murder and remanded to HMP Foston Hall.

2. At a health screen on her reception, Ms Henshaw was noted as having a history of mental illness and had been prescribed antipsychotic medication. Although she reported no other significant health concerns, healthcare staff had access to Ms Henshaw's community health records which recorded that she had a heart condition and had been advised about the potential danger of continuing to take her antipsychotic medication because of this condition. She had chosen to continue.

3. Ms Henshaw had no relevant health concerns during her time at Foston Hall, and there is no record that she ever displayed any symptoms of her heart condition.

4. On 31 August 2018, an officer unlocked Ms Henshaw's cell shortly before 8.00am. She said that she received a response from Ms Henshaw at the time. At approximately 8.40am, another officer discovered Ms Henshaw unresponsive in her cell and called a medical emergency code on her radio. An ambulance was called immediately. Within a few minutes, healthcare staff had attended and started trying to resuscitate Ms Henshaw. Shortly before 9.00am, the ambulance crew arrived. At 9.03am, they pronounced Ms Henshaw dead.

5. The Governor telephoned Ms Henshaw's family to inform them of her death.

6. During the post-mortem examination, the pathologist recorded that an airway device, inserted during the resuscitation attempt, had been inserted incorrectly and may have contributed to Ms Henshaw's death.

## Findings

### Clinical care

7. We agree with the clinical reviewer that the clinical care Ms Henshaw received at Foston Hall was only partially equivalent to that which she could have expected to have received in the community.

8. Healthcare staff did not follow up on missed clinical appointments, and did not schedule reviews, although Ms Henshaw's prescribed antipsychotic medication posed a cardiac risk.

### Emergency response and life support

9. We are satisfied that that staff called a medical emergency code promptly when Ms Henshaw was discovered unresponsive. We are also satisfied that healthcare staff attended promptly and that their decision to attempt resuscitation was correct.

10. However, it appears that an airway device was inserted incorrectly during the resuscitation attempt and that this may have contributed to Ms Henshaw's death.

11. We are concerned that not all healthcare staff had received appropriate life support training.

**Contact with Ms Henshaw’s family**

12. We are concerned that the prison informed Ms Henshaw’s family of her death by telephone, despite Prison Service Instructions making it clear that a notification of death should be carried out in person.

## Recommendations

- The Governor and the Head of Healthcare should ensure that healthcare staff attend ACCT reviews in line with PSI 64/2011.
- The Head of Healthcare should ensure that a robust policy is in place to ensure that prisoners are followed up for clinical reviews and missed appointments.
- The Head of Healthcare should ensure that all healthcare staff are up to date with their training and that their training is appropriate to the role they are performing.
- The Governor should ensure that a member of Prison Service staff informs a prisoner’s family of her death in person, in line with Prison Service Instruction 64/2011.

## The Investigation Process

13. The investigator issued notices to staff and prisoners at Foston Hall, informing them of the investigation and asking anyone with relevant information to contact him. No one responded.

14. The investigator visited Foston Hall on 6 September 2018. He obtained copies of relevant extracts from Ms Henshaw's prison and medical records. The investigator also interviewed four members of staff and three prisoners during this visit.

15. NHS England commissioned a clinical reviewer to review Ms Henshaw's clinical care at the prison. On 14 May 2019, the clinical reviewer and investigator jointly interviewed four members of healthcare staff.

16. We informed HM Coroner for Derbyshire of the investigation. He gave us the results of the post-mortem examination, and we have sent the coroner a copy of this report.

17. The investigator contacted Ms Henshaw's mother to explain the investigation and to ask whether she had any matters she wanted the investigation to consider. Ms Henshaw's mother asked us to consider:

    - whether Ms Henshaw's prescribed medication could have contributed to her death;
    - whether the incorrect fitting of the I-Gel contributed to her death; and
    - the correct timings of events on the day her daughter died.

    We have addressed these concerns in this report.

18. We shared our initial report with HM Prison and Probation Service (HMPPS). They identified no factual inaccuracies but they clarified some issues around staff support and the report has been amended accordingly. They provided an action plan which is annexed to this report.

19. We sent a copy of our initial report to Ms Henshaw's mother. She identified no factual inaccuracies.

# Background Information

## HMP Foston Hall

20. HMP Foston Hall is a closed women's prison serving courts in the Midlands. It holds up to 344 prisoners, including unconvicted and unsentenced women, young adult women under 21 years old and sentenced women, including some serving life sentences.

21. CARE UK provides primary healthcare services. There are daily GP sessions from Monday to Friday, with out of hours provision at other times. Three primary care nurses and a healthcare assistant are on duty during the day, reducing to one nurse and a healthcare assistant from 8.00pm to 7.15am. CARE UK provides mental health provision.

## HM Inspectorate of Prisons

22. The most recent inspection of HMP Foston Hall was conducted in February 2019. Inspectors reported that the prison was well led, with the senior management team demonstrating energy and creativity. They noted that it was a positive environment where prisoners felt safe and violence was rare and minor.

23. Inspectors reported that healthcare services had improved since their last inspection with all prisoners having good access to services. They reported that all staff had completed their mandatory training but not all staff received clinical supervision. Inspectors noted that interactions with patients were professional but personable. They also noted that staff knew how to call for assistance in emergency situations, with 30% of custodial staff trained in basic life support.

## 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 to November 2018, the IMB reported that there had been signs of improvement in the provision of healthcare since the change of leadership in July 2017.

## Previous deaths at HMP Foston Hall

25. Ms Henshaw was the third prisoner to die at Foston Hall since the start of 2016. There were no similarities between her death and the earlier deaths.

## Key Events

26. On 10 July 2017, Ms Georgina Henshaw was charged with murder and remanded to HMP Foston Hall.

27. Ms Henshaw had been involved with mental health services in the community since the age of 13 because of episodes of self-harm. She also had problems with alcohol misuse and an eating disorder. She had been diagnosed with Borderline Personality Disorder and was prescribed anti-psychotic medications to stabilise her mood. She had had several admissions to psychiatric hospitals and was under the care of the community mental health team at the time of her arrest.

28. In April 2017, a consultant psychiatrist had advised Ms Henshaw to stop taking quetiapine and risperidone (anti-psychotic medications) as there was a risk, she could suffer life-threatening cardiac arrhythmias due to QT prolongation. (This is a heart rhythm disorder which can cause a rapid heart rate and poses a risk of cardiac arrest, and which Ms Henshaw had been diagnosed with after taking an overdose.)

29. In June, a consultant psychiatrist recorded that Ms Henshaw was aware of the risk of continuing with this medication but that she chose to continue. He recommended that if Ms Henshaw did not attend further appointments with him or the community mental health team, her medication should be stopped. On 27 June, the consultant psychiatrist noted that he had written to Ms Henshaw to express his concern that she had failed to attend for two follow up appointments earlier that month and emphasising again the risks of her continuing to take quetiapine and risperidone.

30. On 10 July, a nurse performed Ms Henshaw's reception health screen when she arrived at Foston Hall. He recorded her history of alcohol abuse, mental illness and previous self-harm. Ms Henshaw told the nurse that she had no thoughts of self-harm or suicide. She said that she was prescribed 200mg daily of sertraline (an antidepressant), 75mg daily of quetiapine and 2mg daily of risperidone. The nurse referred Ms Henshaw to the mental health team.

31. Later that day, a prison GP reviewed Ms Henshaw's medical notes. He renewed her prescription for sertraline, quetiapine and risperidone. He also prescribed Ms Henshaw a standard regime of alcohol detoxification drugs. He noted that Ms Henshaw's reception screen had detected a possible urinary tract infection, so he prescribed her antibiotics as a precautionary measure.

32. A prison GP made no record of Ms Henshaw having any other significant physical health concerns, although her community medical records were available to healthcare staff at Foston Hall.

33. On 12 July, a healthcare assistant (HCA) undertook a secondary health screen with Ms Henshaw. She recorded that Ms Henshaw had ischaemic heart disease and a 'heart murmur'. (A heart murmur is an unusual sound from the heart which may be related to a heart problem but which often has no cause and is harmless. This appears to be a misinterpretation of the QT prolongation issue.) The HCA made no mention of the QT prolongation but she noted that Ms Henshaw had been advised

about use of her mental health medication in the past in the light of her heart condition.

34. On 13 July, a member of staff from the prison's drug and alcohol rehabilitation team (DART), assessed Ms Henshaw's alcohol detoxification needs. Over the next few months, a member of staff supported Ms Henshaw through her alcohol detoxification. In October, she reviewed Ms Henshaw. She noted that Ms Henshaw felt stable but was feeling stressed about her upcoming trial. Ms Henshaw asked to be referred to Alcoholics Anonymous, so she added her to the waiting list. There are no further entries relating to Ms Henshaw's detoxification.

35. On 20 July, an officer observed that Ms Henshaw had self-harmed by making cuts to her upper arm. She was placed on an ACCT. On 26 July, an officer carried out an ACCT review with Ms Henshaw. She told him that she had self-harmed for 20 years but did not have any thoughts of suicide. An officer closed the ACCT.

36. On 27 July, an officer introduced himself to Ms Henshaw as her personal officer. He discussed why she had been on an ACCT and offered to support her during her early days at Foston Hall.

37. On 24 August, a mental health nurse reviewed Ms Henshaw after her reception screen referral. He requested her mental health history from her GP in the community and scheduled a discussion of her case at a referral meeting. He arranged for Ms Henshaw to be reviewed two weeks later following a blood test relating to her anti-psychotic medication. On 11 September, a prison GP reviewed Ms Henshaw's blood test results, and noted that everything was within normal limits.

38. Officers recorded that Ms Henshaw settled in very quickly at Foston Hall. She received many positive comments during her first few months at the prison. In December, an officer noted that Ms Henshaw enquired about enhanced status and that he supported her application for this.

39. On 5 January 2018, an officer noted that Ms Henshaw had made cuts to her left arm. She noted that Ms Henshaw's trial was due to start in the near future and she opened an ACCT. At an ACCT review the following day, Ms Henshaw told an officer that she was feeling stressed about her trial and used self-harming as a means to cope. She told him that her medication was not working. An officer scheduled a further ACCT review with healthcare staff present. Following a multidisciplinary team meeting on 8 January, Ms Henshaw was referred to the mental health team.

40. On 15 January, a nurse reviewed Ms Henshaw. Ms Henshaw told him that she was struggling and wanted to increase her quetiapine dose. She said that the upcoming trial was causing her stress and that sertraline helped. Two days later, a nurse recorded that Ms Henshaw needed to see a GP for her medication and sent an electronic notification to this effect to the mental health team. On 31 January, a nurse noted that at a mental health medication review, Ms Henshaw had asked for her quetiapine to be increased but was content with her other medication.

41. On 27 February, Ms Henshaw was convicted of murder and given a mandatory sentence of life imprisonment. The court directed that she should serve a minimum of 16 years.

42. On 12 March, a prison GP reviewed Ms Henshaw. Ms Henshaw asked for an increase in her quetiapine dose, so the prison GP referred her to the mental health team. At a multidisciplinary meeting the next day, a nurse was reminded to see Ms Henshaw as she had not been seen since January. Two days later, a nurse saw Ms Henshaw at an ACCT review, where she asked him if she could increase her quetiapine dose. The nurse noted that he would discuss this with the mental health team and psychiatrist, but there is no note of any discussion.

43. On 3 April, a consultant psychiatrist reviewed Ms Henshaw. He added 15mg daily of mirtazapine (an antidepressant) to her medication. The consultant psychiatrist also discussed a referral to CAMEO with Ms Henshaw. (CAMEO is a specialist regime to help people with personality disorders.)

44. On 9 March, an officer recorded that at an ACCT review, it was agreed to reduce Ms Henshaw's observations to four during the night, with two daily conversations. On 19 March, Ms Henshaw's ACCT was closed.

45. On 14 March, an unknown member of staff recorded in Ms Henshaw's electronic medical records that she required annual physical healthcare monitoring, including cardiovascular risk, because of the anti-psychotic medication she was taking.

46. On 1 April, her personal officer noted that Ms Henshaw had taken the news of her sentence well and was making plans for her future and eventual release. She expressed an interest in joining the CAMEO programme.

47. On 1 May, a consultant psychiatrist saw Ms Henshaw and increased her dose of mirtazapine. He saw her again on 22 May when Ms Henshaw said she was due an ECG. He said he would refer her for this, and he also increased her dose of quetiapine.

48. Between May and July, Ms Henshaw was subjected to random mandatory drug testing on three occasions. On each occasion she tested negative for illicit drugs.

49. During her time at Foston Hall, Ms Henshaw had no significant physical health concerns and never demonstrated any symptoms of her underlying heart condition.

## Emergency response

50. On the morning of 31 August, an officer was on duty on Ms Henshaw's wing. At approximately 7.30am, the officer started the roll check on the wing. This involved checking each cell and getting a response from the occupant. The officer told the investigator that Ms Henshaw was lying on her side in bed facing the wall, and that she responded by moving her shoulder. At about 8.00am, the officer unlocked the prisoners. She said she saw Ms Henshaw "shrug" as she looked through her observation panel, so she unlocked her cell before pushing a letter under the partially-opened door. The officer said that she unlocked the rest of the wing without any issues.

51. At approximately 8.15am, the officer was checking off the names of prisoners as they left the wing to go to their various activities. She said that, as usual, a few prisoners had not yet appeared, so she gave their names to Ms Henshaw's personal officer so he could check on them. The officer said that it was unusual that Ms Henshaw should be one of these prisoners. She said that the personal officer made a final call for these prisoners over the intercom, while she herself returned to the office. The officer said that she then received a phone call asking about Ms Henshaw because she had not arrived at her activity. She passed the call over to the personal officer, who then went to check on Ms Henshaw.

52. The personal officer told the investigator that an officer gave him a list of four prisoners who had not left for their activities, and that he was surprised to see Ms Henshaw on the list because she was never late. He said that, at approximately 8.30am, somebody telephoned to ask about Ms Henshaw, so he went to check on her. The personal officer knocked on her door to make sure she was decent, and then looked through her observation panel. He said that Ms Henshaw appeared to be asleep, so he went into her cell while speaking loudly. He tapped her shoulder but got no response. The personal officer said that he shook Ms Henshaw but that her body returned to the same position, so he immediately called a code blue emergency over the radio. (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 personal officer said that an officer arrived after approximately 20 seconds. He said that he checked for a ligature while, for decency reasons, an officer checked for any other injuries. He said that Ms Henshaw's face was blotchy. He said that he checked for a pulse and thought he detected one but could not be sure whether this was Ms Henshaw's or his own as he had not been trained in first aid.

54. He said that, at one point, the officer asked where healthcare staff were, so he checked outside the cell. He saw some healthcare staff on the wing so called them over to Ms Henshaw's cell. He then heard the phone ringing in the wing office so went to answer that. As he reached the office, he saw a Custodial Manager (CM) and a Supervising Officer (SO) arrive on the wing.

55. An officer said in interview that she heard the personal officer call for assistance over the radio and that she ran to Ms Henshaw's cell. She said that she checked for a ligature or blood, but there was nothing. The officer said that healthcare staff arrived after maybe a minute or so. She moved a chair out of Ms Henshaw's cell to given them more room to work, and then left to lock up the other cells on the wing. The officer said that the letter she had placed on the floor of Ms Henshaw's cell earlier was on the chair and appeared to have been opened.

56. A nurse and an HCA heard the code blue call and responded. The nurse noted that an officer directed them to Ms Henshaw's cell. Another officer told her that Ms Henshaw was unresponsive but that she thought that she was breathing. The nurse noted that Ms Henshaw's skin was mottled and she was not responding to her calls. She could not find a pulse and asked the HCA to request further assistance. A second nurse arrived a few seconds later.

57. In interview, a nurse said that Ms Henshaw appeared purple and was mottled all over. She said that she was warm to the touch and there was no evidence of rigor mortis or other signs of death. The nurse said that she had encountered dead bodies in her previous job, and that Ms Henshaw's appearance was similar. She recorded that the second nurse moved Ms Henshaw to the floor of her cell and started cardiopulmonary resuscitation (CPR).

58. In interview, the HCA said that Ms Henshaw appeared purple and mottled. She said that she could not see any signs of life and that she did not respond to pain stimuli. The HCA said that when the second nurse arrived, she assumed a supporting role. She said that she helped to attach the defibrillator and handed an I-Gel and Ambu-bag to the second nurse. (An I-Gel is a curved tube designed to be inserted with the use of lubrication into a patient's throat to allow air to be delivered unhindered via an Ambu-bag.) The HCA said that she did not witness the second nurse insert the I-Gel but was not aware of her having any problems in doing so. The first nurse also said that she was unaware of any difficulties.

59. The second nurse told the investigator that she was taking a clinic when she heard the code blue call over the radio. She excused herself from her patient and went to Ms Henshaw's cell. When she arrived, Ms Henshaw was in bed and another nurse and an HCA were with her. She said that she removed a sheet covering Ms Henshaw and saw that her skin was purple and mottled. She said that it was "very, very clear that she was no longer alive" but that she was confused because Ms Henshaw was warm. She confirmed that she was aware of NHS guidance about CPR and felt that, on balance, it was appropriate to commence CPR because there was no rigor mortis present and Ms Henshaw was still warm.

60. She said that she had been trained to insert an I-Gel, although this was the first time she had used one with a human being. She said she had no difficulty inserting the device and that there is only one way an I-Gel can be inserted. She said that she was sure she had inserted it correctly because she observed that Ms Henshaw's chest rose and fell as she delivered air through the Ambu-bag.

61. A CM and a SO both heard the code blue emergency called and both responded. They met on the way and attended together. In interview, the CM said that as they entered the wing, they saw the personal officer going to answer the wing office phone. Two healthcare staff were providing life support to Ms Henshaw and told him that she had suffered a cardiac arrest. The CM went to the office to tell the personal officer while he was on the telephone to the ambulance operators. The personal officer passed this information on and confirmed that the ambulance was on its way. The CM said that shortly afterwards he heard ambulance sirens, so he instructed security staff to open the gates and to secure a route for the ambulance.

62. In interview, a SO said that an officer told her what had happened. The SO took control of the situation and kept a log of events. She asked the personal officer to sort out a gate pass and asked the officer to secure the cells on the wing. The SO said that the personal officer and officer appeared affected by the incident, so while healthcare staff were proving support, she sent them on a break.

63. The control room log records that at 8.40am the personal officer called a code blue emergency on the radio. At 8.44am, the ambulance operator was connected to the

personal officer on the wing.  At 8.57am, the log records that the ambulance crew had arrived at C Wing.

64. At 9.03am, the control room log recorded that Ms Henshaw had died. At 9.11am, the ambulance left the prison.

65. The SO said that Ms Henshaw was left in her cell after the ambulance crew left. She closed the curtains of the cell and covered the observation panel.

## Post-mortem report

66. The post-mortem could not establish a definitive cause of death for Ms Henshaw and recorded the cause of death as unascertained.

67. The pathologist considered a suggestion by a consultant cardiologist that Ms Henshaw could have died from sudden arrhythmogenic death syndrome but noted that this could not be diagnosed from an autopsy examination.

68. The pathologist recorded that toxicology tests found evidence of quetiapine, risperidone and mirtazapine at levels consistent with Ms Henshaw's prescription. Sertraline was found at above therapeutic levels but the pathologist said that this did not necessarily mean that Ms Henshaw had taken more than she was prescribed as sertraline can increase within a body after death.  He also noted that the sertraline was at levels lower than that found in fatal cases.

69. There was no evidence of alcohol or PS.

70. The pathologist observed that the I-Gel had been inserted in Ms Henshaw's windpipe back to front.  He commented that this could have caused airway obstruction and deprived Ms Henshaw of oxygen.  He was unable to say when the I-Gel was inserted, and whether Ms Henshaw was already dead, but noted that there was bruising to the back of Ms Henshaw's throat, which indicated that she may have still been alive at that point.  He recorded that if this was inserted while Ms Henshaw was in cardiorespiratory arrest, this would have compromised the resuscitation attempts and could have contributed to her death.

## Information from other prisoners

71. After Ms Henshaw's death, other prisoners told the investigator that Ms Hensahw regularly used psychoactive substances (PS) such as 'Spice' and 'Mamba'.  Prison and healthcare staff said they were not aware that this was the case.

## Contact with Ms Henshaw's family

72. Ms Henshaw's next of kin was her mother.  At 10.00am, the Governor telephoned Ms Henshaw's mother to inform her of her daughter's death.  She recorded that she offered to visit her at home but that Ms Henshaw's mother said she would come to the prison instead.  Shortly afterwards, the prison appointed an officer as Ms Henshaw's family liaison officer (FLO).

73. At 2.25pm, the FLO met Ms Henshaw's mother, father and friend as they arrived at the prison and took them to Governor's office. The Governor explained the procedures to follow and offered her support.

74. The Governor and FLO continued to liaise with Ms Henshaw's family. Ms Henshaw's funeral was held on 10 September and the prison contributed to the cost in line with national guidance. Ms Henshaw's mother requested that, following the funeral, her daughter's ashes be spread in the prison grounds.

## Support for prisoners and staff

75. After Ms Henshaw's death, the Deputy Governor 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.

76. In interview, the HCA said that the former Deputy Head of Healthcare, was "brilliant". A nurse said that the support she had received from the former Deputy Head of Healthcare was "incredible".

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

# Findings

## Clinical care

78. The clinical reviewer concluded that the care Ms Henshaw received at Foston Hall was of mixed quality and only partially equivalent to that which she could have expected in the community.

79. Ms Henshaw's substance misuse care for her alcohol problem was well managed from reception screen. However, there are no documented entries in her medical notes after October 2017 and no rationale given for not seeing her for further sessions.

80. Her contact with the mental health team was inconsistent, with follow-up appointments often missed. The clinical reviewer also noted that mental health staff did not always attend her ACCT reviews. We recommend that:

    **The Governor and the Head of Healthcare should ensure that healthcare staff attend ACCT reviews in line with PSI 64/2011.**

81. With regard to Ms Henshaw's underlying heart condition, the clinical reviewer is concerned that, although her heart condition was recorded in her medical records, staff did not investigate this further. He noted that Ms Henshaw's previous medical history was available to clinical staff via her electronic medical records, and that there were entries identifying her as having a QT Prolongation issue. He observed that there was confusion about this, with staff incorrectly recording that she had a heart murmur.

82. The clinical reviewer observed that Ms Henshaw failed to attend several ECG appointments and for an annual health screen. He considered that as Ms Henshaw was on prescribed antipsychotic medication, these reviews were important because of the increased cardiac risk she faced. The Deputy Regional Manager for CARE UK, said that a system is now in place to ensure that prisoners are chased up after missing appointments, or where regular reviews are required. We recommend that:

    **The Head of Healthcare at Foston Hall should ensure that a robust policy is in place to ensure that prisoners are followed up for clinical reviews and missed appointments.**

## Emergency response and life support

83. Prison Service Instruction (PSI) 03/2013, *Medical Response Codes*, requires prisons to have a two-code medical emergency response system in place. A code blue call should be used to indicate an emergency when a prisoner is unconscious, or having breathing difficulties, and code red when a prisoner is bleeding. Calling an emergency medical code should automatically trigger the control room to call an ambulance.

84. When the personal officer discovered Ms Henshaw unresponsive, he immediately called a code blue emergency on the radio. Healthcare staff responded promptly

and were with Ms Henshaw within a few minutes. An ambulance was called immediately and arrived a little over 15 minutes after the emergency call.

85. When the personal officer spoke to the ambulance operators on the phone, he had to reiterate that an emergency ambulance was required. However, we find that this was purely to confirm that attendance was required because the ambulance arrived very shortly afterwards.

86. We are satisfied that the emergency response was triggered appropriately, and that healthcare staff arrived on scene promptly.

**The decision to resuscitate**

87. Trying to resuscitate someone who is clearly dead is distressing for staff and undignified for the deceased. In September 2016, NHS England issued formal guidance entitled: '*Guidance to support decision making for when not to perform CPR in prison and IRCs'*. This guidance adopted the European Resuscitation Council Guidelines of 2015, which states: "Resuscitation is inappropriate and should not be provided when there is clear evidence that it will be futile …", for example, where rigor mortis is present. In 2016, the British Medical Association (BMA), the Royal College of Nursing (RCN) and the Resuscitation Council (UK) issued revised guidance about making appropriate resuscitation decisions. The guidance states that every decision should be made on the basis of a careful assessment of each individual's situation.

88. Healthcare staff attending to Ms Henshaw were confused by her appearance because she appeared to be dead, but that she was still warm and there was no sign of lividity or rigor mortis. A nurse said that she was aware of the 2016 guidelines but felt that it was appropriate to attempt resuscitation. We are satisfied that healthcare staff correctly decided to start CPR when they did, because there was no conclusive evidence that this would have been futile.

**Issues with the I-Gel**

89. The post-mortem report raises serious concerns about the insertion of the I-Gel. The pathologist who performed the autopsy reported that the I-Gel was inserted incorrectly, and that this could have contributed to Ms Henshaw's death by blocking her breathing. The report highlights the fact that there was bruising to the back of Ms Henshaw's throat from this insertion and that this suggested that she was still been alive when the I-Gel was inserted.

90. We accept that a nurse believed she had inserted the I-Gel correctly. We also note that the other healthcare staff present stated that they were not aware of any trouble inserting the I-Gel, although they had not directly witnessed it being inserted. The nurse had recently completed her intermediate life support training (ILS) training, and said in interview that, although she had not previously used an I-Gel on a person, there is really only one way in which an I-Gel can be inserted. However, there is no evidence to suggest that the I-Gel was moved after Ms Henshaw had died or that it was inserted by anyone other than a nurse, and the nurse has been unable to explain the pathologist's findings.

### Clinical staff training

91. Healthcare staff at Foston Hall are required to complete life support training annually. A nurse had completed her ILS in May 2018 and an HCA completed her ILS training in February 2018. However, a nurse had not completed ILS training, and had only completed her basic life support training (BLS) when she qualified as a nurse in 2016. (ILS training covers the use of an I-Gel, but BLS only covers the basics of life support and does not cover the use of an I-Gel.)

92. We share the clinical reviewer's concerns that a nurse had not had the appropriate life support training. We make the following recommendation:

    **The Head of Healthcare should ensure that all healthcare staff are up to date with their training and that their training is appropriate to the role they are performing.**

## Roll checks and unlocking procedure

93. A roll check is primarily a security check to count prisoners to ensure that they are present in their cells, but it is also an opportunity for any concerns about prisoners' safety to be identified and addressed. At unlock, officers should take active steps to check on a prisoner's wellbeing. The Prison Officer Entry Level Training (POELT) Manual says:

    > 'Prior to unlock, staff should physically check the presence of the occupants in every cell. You must ensure that you receive a positive response from them by knocking on the door and await a gesture of acknowledgement. If you fail to get a response, you may need to open the cell to check. The purpose of this check is to confirm that the prisoner has not escaped, is ill or dead.'

94. Prison Service Instruction (PSI) 75/2011, *Residential Services*, says:

    > 'Reports from the Prisons and Probation Ombudsman on deaths in custody have identified cases in which a prisoner has died overnight … but staff unlocking them have not noticed that the prisoner had died. This is not acceptable ...
    >
    > '[Differing] arrangements will depend on the local regime, but there need to be clearly understood systems in place for staff to assure themselves of the wellbeing of prisoners during or shortly after unlock ... Where prisoners are not necessarily expected to leave their cell, staff will need to check on their well-being, for example by obtaining a response during the unlock process.'

95. An officer was the last person to have seen Ms Henshaw before she was discovered unresponsive. She reported that Ms Henshaw responded by moving her shoulder when she checked her cell shortly after 7.30am and that Ms Henshaw shrugged as she unlocked her cell shortly after 8.00am. When Ms Henshaw was discovered half an hour later, the officer said that a letter she had placed on the floor of Ms Henshaw's cell at unlock, was on a chair in her room and had been opened.

96. Clinical staff thought that Ms Henshaw may have been dead for some time when they arrived. However, in interview they all stated that Ms Henshaw was still warm and, as discussed above, they all agreed with the decision to start resuscitation. We also note that the pathologist reported bruising to the back of Ms Henshaw's throat from the I-Gel, which suggests that she was still alive at the time when resuscitation was started.

97. Given the information available, it seems likely that Ms Henshaw was alive when an officer unlocked her cell.

## Support for staff

98. We are satisfied that custodial staff were appropriately supported following Ms Henshaw's death. However, healthcare staff have expressed their concerns that while the support they received immediately after Ms Henshaw's death was very good, this support did not continue to the same level in the long term. We consider that the Head of Healthcare should have ensured that staff were offered ongoing support.

**The Head of Healthcare should ensure that staff are offered support after any death in custody and that this support should continue for as long as is necessary.**

## Contact with Ms Henshaw's family

99. PSI 64/2011, *Safer Custody*, says that ""Wherever possible, the FLO and another member of staff must visit in person the next of kin or nominated person to break the news of the death …If a face-to-face prison notification is not possible or where another prison's FLO or the police have visited the family, then a follow up visit by the prison must be arranged as soon as practicable."

100. We are very concerned that the prison informed Ms Henshaw's mother of her daughter's death by telephone. While we accept that Ms Henshaw's family were informed promptly, there appears to have been no consideration about informing them in person. It is clear from the PSI that the notification of the death of a prisoner should be in person, so we make the following recommendation:

**The Governor of Foston Hall should ensure that a member of Prison Service staff informs a prisoner's family of her death in person, in line with national guidance.**

## Inquest

101. The inquest into Ms Henshaw's death concluded that she died of natural causes due to a sudden cardiac arrythmia.

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 I 020 7633 4100