

**The Death in Custody of
a woman at
HMP Bronzefield in October 2005**

**Report by the Prisons and Probation Ombudsman
for England and Wales**

October 2006

This is the report of an investigation into the circumstances surrounding the death of a woman in hospital on 20 October 2005. Her death was caused by cerebral compression due to a brain abscess. She was 30 years old. At the time of her death, the woman was a prisoner at HMP Bronzefield.

I extend my sincere condolences to the woman's family and friends for their loss.

The investigation was carried out by one of my colleagues. A clinical review into the woman's care and treatment was carried out by a qualified nurse and who also works for my office. In addition a Nurse Consultant on Substance Misuse, carried out a review of the management of the woman's detoxification programme. Her review also comments on other aspects of the woman's care and treatment.

I would like to thank the Director of Bronzefield, and her staff for their help. I would also like to thank the Director and the contractor, UKDS, for action already taken following early disclosure of an interim draft of this report.

The condition from which the woman died is not common, but it is one with which clinicians should be aware and is treatable. The two clinical reviews are very critical of the clinical care and treatment afforded to the woman. She had been at Bronzefield for just over three weeks by the time of her death, but it was only in the final hours of her life that she was recognised to be unwell and sent to outside hospital for further assessment. By then, it was too late.

I have made 20 recommendations, all of which are taken from the two clinical reviews obtained in this case.

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SUMMARY

On 27 September 2005, the woman was received into HMP Bronzefield after being convicted for breach of a community order. At that time, she was awaiting sentencing.

Upon arrival at Bronzefield, she saw a nurse who carried out a first reception health screening assessment. During this assessment, the woman reported that she used heroin, cocaine and methadone. She also reported that she had consulted her GP in the previous few months about a groin abscess and a severe headache. She said on the form that she was concerned about her headache. Although the woman supplied the name of her doctor, Bronzefield did not make contact with the GP.

The following day, 28 September, the woman was seen by a local GP providing primary medical services to Bronzefield. In their consultation the woman did not mention any concern about headaches and so the GP did not explore that condition with her. The GP prescribed medication for drug detoxification and antibiotics for the woman's groin abscess. Treatment for her drug detoxification commenced without delay, but six days went by before the antibiotics were issued by the prison pharmacy.

A friend of the woman said that she continued to suffer with headaches and was also having 'drop' (fainting) fits. However, from 29 September to 19 October, the only reference to either condition in the woman's custodial and medical records was when she fainted in the gym on 29 September.

At about 10pm on 19 October, the woman pressed the call bell in her cell and told a Prison Custody Officer (PCO) that she had a headache. The woman was told that, at night time, nurses did not usually visit prisoners who were only complaining of a headache. At around 5am the following morning, the woman pressed her call bell again and told the PCO that her headache was now more severe and the pain was also running down the side of her body. This time the woman was told that nurses did not visit prisoners after about 4am in the morning.

When the day staff came on duty at 7.30am, a Senior Prison Custody Officer (SPCO) saw that the woman had been complaining through the night about a headache. He arranged for her to be first to see the nurse who would be issuing the morning medication.

As the woman was walking to the medication room at around 8am, the SPCO saw she was unsteady on her feet, so she was given a chair to sit on. A nurse tried to question the woman about her symptoms, but she was not very responsive. The woman was given two paracetamol tablets. After this, the woman's friend was asked to stay with her to keep a check on her condition.

For the next two hours, a PCO made frequent visits to see the woman. He did not notice any deterioration in her condition and said that she made no complaints to him that she was in pain. The woman's friend said the woman's

arm was going numb, she was losing consciousness and she was incontinent. She said that she was told by a PCO that the staff were waiting for healthcare to arrive on the wing. The woman's friend's account is not consistent with that given by the PCO.

At about 10.30am, a pre-arranged fire drill took place. Two other prisoners supported the woman as they walked to the assembly point – a small courtyard just outside the prison wing. The woman was unsteady on her feet and she sat on a low concrete plinth. After about 15 minutes, the officers decided that the woman should be checked by a nurse. A nurse came to see her. The woman was able to converse with the nurse and to answer the questions she was asked. The nurse decided to take the woman to the healthcare unit for further observation, but at interview with the investigator said that she did not think that the situation was serious.

When they arrived in healthcare, the nurse took clinical observations of pulse and blood pressure and checked the woman's pupils. These checks did not give the nurse any cause for concern and so she left her while she carried out other duties. When the nurse returned to the woman's room at around midday, she was sitting on the floor and had been incontinent of urine. On checking the woman's eyes, the nurse saw that her right pupil was dilated (enlarged) and was sluggish in reacting to light. The nurse asked the GP to check the woman and he quickly decided that she should be transferred to outside hospital. The ambulance service was contacted at 12.25pm.

The woman arrived at hospital at about 1.15pm. Her condition deteriorated very quickly from then on and at 6.30pm it was noted that the hospital doctors had advised that she would not survive. The woman died at around 9.30pm. The cause of death was cerebral compression caused by a brain abscess.

The condition from which the woman died is not a common one and would not, perhaps, be the first diagnosis that would come to a clinician's mind in dealing with a patient. However, based upon the findings from the two clinical reviews obtained in this case, I judge that opportunities were missed during the woman's time in Bronzefield that meant that the clinicians involved did not put themselves in the best possible position to reach the correct diagnosis at an earlier stage.

I have made 20 recommendations.

INVESTIGATION PROCESS

The investigation was opened on 27 October 2005, when my investigator visited Bronzefield and met the prison's Security Manager who liaised closely with the woman's family on the day she was sent to hospital and where she subsequently died. My investigator also met the Home Office Controller, the chairperson of the prison's trades union and members of the Independent Monitoring Board (IMB). My investigator informed those he met of the nature and scope of the investigation. Notices were issued to staff and prisoners notifying them of the investigation.

A trained nurse was appointed to carry out a clinical review of the woman's care and treatment. My investigator and the clinical reviewer visited Bronzefield and carried out a number of formal interviews with staff and also spoke with a prisoner. The clinical reviewer investigator subsequently carried out several further interviews with staff by telephone.

One of my Family Liaison Officers contacted the woman's mother to inform her of the investigation.

HMP BRONZEFIELD

HMP Bronzefield is a new prison in Ashford, Middlesex, which opened on 17 June 2004. It is a purpose built women's prison privately operated by United Kingdom Detention Services (UKDS) and was the first women's prison in the UK to be managed by the private sector. UKDS operates two other prisons, HMP Peterborough and HMP Forest Bank in Salford. Bronzefield performs the role of a local prison, taking prisoners directly from the courts. Additionally, sentenced women may serve some of their sentence there. Bronzefield holds around 450 prisoners.

Accommodation at Bronzefield is provided in three houseblocks with mostly single cells. Each houseblock is made up of four spurs of two landings each containing 34 or 35 cells. There is also a unit for twelve mothers with babies.

The healthcare centre provides 18 in-patient beds. There is 24 hour nursing cover. A doctor is available on site from 10am to 5pm, with an on-call service operating outside of these times.

Bronzefield received an announced inspection by Her Majesty's Chief Inspector of Prisons (HMCIP) in June 2005. In her introduction, the Chief Inspector said that over all it was a good report. The introductory paragraph to the healthcare section of the report stated:

Prisoners at Bronzefield had a poor perception of the quality of healthcare ... Most complaints were about poor communication and delays in seeing healthcare staff. Prisoners overwhelmingly raised this as a serious concern. Staff acknowledged that healthcare services had been poor until recently, but much had improved and was improving. A new head of healthcare had been appointed and there was a stable staff group working within a clear clinical management structure ... Despite the negative perceptions, we observed very professional care from highly motivated and caring staff to prisoners with very complex and challenging needs.

The woman's death was the second death of a prisoner at Bronzefield since its opening. The first death occurred four weeks before the woman's death. In one other case, a woman died in July 2004 within a few hours of being released from Bronzefield. Both cases were investigated by the Ombudsman.

THE WOMAN

The woman was born on 4 January 1975 and grew up in Sussex. She had one sister and one brother. When she was eight, her father died of a heart attack at a young age. The woman left school with a number of qualifications, including mathematics and English. After leaving school, the woman did shop work and later became a restaurant manager.

The woman's first criminal conviction was in relation to offences of theft, deception and handling stolen goods, occurring in late 1999. She was placed on a probation order for two years. Following that first conviction, the woman was convicted for many similar offences over the following years. She was sentenced to a number of separate terms of imprisonment for periods ranging from one to four months.

The woman informed a probation officer that all her offences were linked to heroin and cocaine addiction.

THE EVENTS OF 27 SEPTEMBER TO 19 OCTOBER

On 27 September 2005, the woman was convicted at Magistrates' Court for breach of a community order. While awaiting sentencing, she was remanded into HMP Bronzefield and she arrived there later that same day.

Upon arrival in Bronzefield, the woman received a First Reception Health Screen assessment with a prison nurse. During this assessment, the woman supplied the name and address of her doctor and reported that in the previous few months she had consulted her doctor about symptoms of a severe headache and a groin abscess. In answer to a question about whether she had any concerns about her health, the woman replied that she was concerned about her headaches. She declared that she was a user of illegal drugs and a urine test proved positive for heroin, methadone and cocaine/crack. The woman signed a form giving her consent for her doctor to release information about her medical history. She was allocated a single cell in C spur of houseblock 1. (Houseblock 1 is the induction and detoxification unit. The majority of cells in Bronzefield are single cells.)

On 28 September, the woman was seen by a GP, one of the prison doctors. The GP's note of his consultation with her mentioned her groin abscess, which he noted as 'improving' and for which he prescribed two antibiotics and an anti-inflammatory drug. However, the GP made no reference to headaches. At interview with the investigators the GP said that he would have seen the First Reception Health Screen form that included the references to headache. His practice, however, was to ask open ended questions and when he asked the woman whether she had any concerns or worries, she made no reference to headaches and so he did not ask her any direct questions about that condition. He added that she did not ask for stronger painkillers than the paracetamol that he prescribed for symptoms of drug withdrawal. There is no documentary evidence of the woman mentioning headaches in four subsequent consultations with other health professionals. Given her declared use of opiates and cocaine and the positive urine test result, the GP prescribed Lofexidine for the symptoms of opiate withdrawal and diazepam for withdrawal from Benzodiazepine.

On 29 September, the woman attended gym induction (part of the prison induction programme). During gym induction, prisoners receive some basic health and fitness checks and are shown how each piece of equipment works. The woman fainted while receiving induction and a nurse was called to examine her. The nurse told the investigators that, when she got to the gym, the woman was lying on the floor. She was alert and wanting to get up, but staff had told her to stay on the floor. The woman said that she had not been well since being on Lofexidine. The nurse took the woman's blood pressure and pulse. After this, the woman was taken to an office in the gym and was given a cup of tea. At interview, the nurse said that, as Lofexidine sometimes lowers the blood pressure, she thought that that might have been why the woman fainted. When the nurse took the woman's blood pressure, however, she found it to be $^{141}/_{90}$ (a slightly elevated reading).

Although the GP had prescribed antibiotics and an anti-inflammatory drug on 28 September, these drugs were not issued to the woman until 3 October. It seems that there was a delay in this medication being supplied by the prison pharmacy, but

precisely why there should have been such a delay, or even any delay, is unclear. Once these drugs were supplied, the woman was issued a seven day supply for her to hold in her own possession.

On 4 October, the woman reported that she had overdosed by taking 14 of her in-possession antibiotic tablets. The remainder of her in-possession medication was taken away from her, although nothing was documented about precisely how many tablets were taken from her. No note was made about whether she was spoken to about her reasons for taking the overdose. However, an entry was made in the woman's medical records that in future, she was not to be issued with in-possession medication.

Entries were made in the woman's prescription chart showing that she was issued medication in single doses for the remainder of 4 October, and throughout 5 October. However, it is unclear from these entries whether she was issued all of the drugs that had been prescribed for her.

Despite the fact that a note had been made in the woman's medical records that she should not be re-issued with in-possession medication, three days' worth of in-possession medication was in fact issued to her on 6 October.

On 8 October, the woman moved to a single cell in D spur of houseblock 3.

The investigators spoke to a friend of the woman, a prisoner at Bronzefield who knew her. The friend said that the woman had been suffering from 'drop fits' while in Bronzefield and had told the officers that she was suffering from headaches. The friend also said that the woman had not been eating or drinking in the last week of her life.

Although it was recorded that the woman fainted in the gym of 29 September, her records contain no other reference either to headaches or fits apart from her first and last days at Bronzefield. Nor do the woman's records contain any entries to suggest she was failing to eat.

One of the officers told the investigators that the woman had complained about headaches in the last two days of her life and he had advised her to ask for some painkillers at medication rounds. In these final days, one of the PCO's thought that the woman was looking very tired and that, when coming down the stairs at meal times she would walk slowly while holding on to the banisters. Also at around this time there was an occasion when the PCO saw the woman having a fit. He believed that a nurse was called from healthcare to deal with that problem.

On 19 October, the woman wrote a letter to her partner (which was never sent). In her letter she wrote: *'I haven't gone to work at all today, I'm suffering severe migraines, so I've been told ...'*

THE NIGHT OF 19 OCTOBER AND THE DAY OF 20 OCTOBER

In a telephone interview, the night PCO told the clinical reviewer that at around 10pm on 19 October, the woman pressed her cell call bell. She said that she had a bad headache and needed painkillers. As the night PCO had not previously worked at night time, she did not know the procedures for dealing with an event such as this and sought guidance from another officer. The night PCO was told that healthcare nurses did not usually come out to prisoners at night for complaints of a headache. The night PCO passed this information to the woman, who accepted what she was told.

At about 5am on 20 October, the woman pressed her call bell again. She told the night PCO that her headache was more severe and the pain was now running down the right hand side of her body. The night PCO said that she telephoned a nurse in healthcare who said that nurses did not visit prisoners after a certain time in the morning – the night PCO thought the nurse said after 4am – and that the woman would have to wait until the morning medication round. The night PCO went to the woman's cell to inform her of this, but she was underneath her bedclothes and seemed to be sleeping. The night PCO therefore left without speaking to her.

Also in a telephone interview, the night nurse told the clinical reviewer that she was on duty during the night of 19/20 October and received a telephone call from the night PCO at around 5am. The night PCO said that a prisoner was complaining about a headache/migraine and had tingling in the side of her face. The night nurse asked the night PCO whether the prisoner had any other symptoms, such as vomiting, but there were no other symptoms. There was nothing to indicate to the night nurse that this was an emergency situation, so she told the night PCO that the woman could not be given any medication at that time as it would interfere with her morning medication. The night nurse told the night PCO to telephone again if there were any further problems.

In her discussion with the clinical reviewer, the night nurse went on to explain that Bronzefield's policy, in general, was only to issue medication at night time if it was absolutely necessary. She said that she had written a procedure on medication and this had been distributed to the house blocks. The night nurse said that at night time there were usually just two nurses on duty; personally, she did not think this to be sufficient.

A Senior Prison Custody Officer (SPCO) said that, when he came on duty on 20 October, he read the occurrence book and saw an entry timed 5am that the woman had been complaining all night about a bad migraine. At about 7.35am, the woman rang her cell call bell again and once more reported that she had a severe headache. Prisoners were due to be unlocked for medication at 7.45am and the SPCO asked a PCO to ensure that the woman was first in the medication queue. A Residential Manager was also present at this time and confirmed the instructions given to staff. From a Residential Manager's point of view he was satisfied that everything was being done to help the woman. The SPCO said that when he saw the woman walking after leaving her room, he could see that her problem was more than a headache – she was unsteady on her feet and was very pale. The SPCO got a chair for her to sit on and he told the medication nurse about the woman's

complaints of a headache. The SPCO said that the medication nurse did not come out of the medication room. Instead, she spoke to the woman through the medication hatch; this surprised him (the residential manager's evidence, however, was that the medication nurse did come out of the medication room).

The PCO confirmed what the SPCO said about ensuring that the woman should be first in the medication queue and that she was unsteady on her feet.

The medication nurse said that she only worked part time at Bronzefield – working as and when shifts were offered to her. On 20 October, she was due to deal with the morning medication round. The medication nurse explained at interview that this is a busy duty due to the number of women receiving medication, several of whom receive vitally important medication such as insulin. The medication nurse said that the SPCO told her that one of the prisoners had been complaining about a headache all night and he asked that something be given for that symptom. The medication nurse had not previously met the woman. The woman was being supported by an officer and she was then given a chair to sit on. The medication nurse said that she knelt in front of the woman and asked her how she was feeling. She looked drowsy and did not respond to the question. The medication nurse told the woman that she understood she had a headache and the woman muttered something in reply. The medication nurse asked the woman whether she had taken any medication and she shrugged her shoulders. The medication nurse then asked the woman whether she would be able to swallow two paracetamol tablets and the woman nodded. While the woman was swallowing the paracetamol with water, the medication nurse asked an officer why the woman was not talking. The officer replied that he did not know. The officer then said that he would take the woman back to her cell and then bring the other prisoners waiting for morning medication.

The medication nurse told the investigators that she did not think that the woman's condition needed urgent attention – the SPCO had said that the night nurse had not thought her condition serious enough for her to be seen during the night. The medication nurse added that, at that time in the morning, the only nursing support available is the 'response nurse' who deals with emergency situations. This meant that there was no nurse on duty at that time to which the medication nurse could have referred the woman for a full, non-emergency, examination. The medication nurse said that procedures have changed since the time of the woman's death. The procedure now is that there is a nurse triage system in place that allows time for those prisoners with health issues to be seen by the nurse after the medication rounds are completed.

The PCO said that, after the woman had been seen by the medication nurse he took her to a cell on the ground floor and he asked another prisoner, the woman's friend, to keep a watch on her. The cell used was not the woman's own cell – her cell was on the first floor and the PCO thought it safer to keep her on the ground floor as she was unsteady on her feet. The PCO said that over the next few hours he kept popping into the cell to check on the woman. During this time she was sometimes awake and sometimes asleep. The PCO did not perceive any real change in the woman's condition through the morning and, as far as he could recall, she made no complaints to him about being in pain.

The woman's friend said that officers asked her to look after her friend once she had been seen by the medication nurse. The woman came into her friend's cell and sat on her bed. The woman's friend told my two colleagues that the woman's arm and hand were going numb and she was losing consciousness. The friend said that the woman wet the bed, but we have not been able to substantiate this (it was not until after her admission to healthcare that any incontinence was apparent to staff). The friend said that she spoke to the PCO and he said that he was waiting for healthcare to arrive.

At about 10.30am, a scheduled fire drill took place. This required all the prisoners from D spur (where the woman was based) to move to a small courtyard adjacent to the spur. The PCO said that the woman walked to the courtyard, but two prisoners supported her as she was walking. When they got to the yard the woman sat down on a low concrete plinth that prisoners use as seating. Two prisoners sat down either side of her. After about 10 or 15 minutes, the PCO asked a prisoner to call the SPCO for him to check on the woman. At interview, the PCO said that he could not recall what triggered him to ask for the SPCO's opinion at that particular moment. The woman was still conscious at this stage.

The SPCO said that when he saw the woman in the courtyard she looked pale and her eyes were closed. The SPCO ran to healthcare and asked a nurse to see the woman.

The healthcare nurse said that, when she went to see the woman, she asked her how she was feeling. She replied that she had had a headache for the past month or so. The woman was alert and was able to answer other questions that the healthcare nurse asked her, for instance whether she had had breakfast. She was displaying no obvious signs of distress. The healthcare nurse decided to take the woman to healthcare in order to take clinical observations. The healthcare nurse collected a wheelchair and took the woman to healthcare. It did not seem to the healthcare nurse that the situation was serious at that stage. When they got to healthcare, the healthcare nurse took the woman to one of the empty cells. With minimal assistance, the woman was able to transfer from the wheelchair to the cell bed. The healthcare nurse took clinical observations of the woman's pulse and blood pressure and also checked her pupils. These checks did not indicate any abnormalities. The healthcare nurse told the woman to lie down and rest and that she would return to check her later on. It was by then approaching lunch time and the healthcare nurse had a few tasks to carry out, including helping at the doctor's morning clinic. When the healthcare nurse returned to the woman's cell, the woman was sitting on the floor. She had been incontinent of urine. The healthcare nurse asked her how she was feeling and asked her why she was on the floor. The woman's reply was incoherent. The healthcare nurse asked her to sit on her bed, and she was able to do that. The healthcare nurse examined the woman and noted that her right pupil was dilated and was sluggish in reacting to light. She said she had a headache. The healthcare nurse then went to ask for the doctor's assistance. The healthcare nurse's entry in the medical records is timed at 12.05pm.

The GP confirmed that at about 12.10pm he was asked by the healthcare nurse to see a prisoner about whom she was concerned. The GP examined the woman and found that her right eye was dilated and sluggish. The healthcare nurse told him

that the woman had been having headaches for several days, but when he tried to question the woman about her symptoms she was largely unresponsive. The GP said that, having observed those neurological symptoms, he decided that she needed to be transferred to outside hospital for urgent assessment.

Records made at Bronzefield show that ambulance paramedics reached the woman at 12.35pm and she was subsequently transferred to a general hospital about 10 miles from Bronzefield. Despite treatment at the hospital, the woman died that evening.

THE WOMAN'S CAUSE OF DEATH

At post mortem, the woman's cause of death was recorded as cerebral compression caused by a brain abscess. In her case, the abscess had formed in the right frontal lobe of her brain. The following information about brain abscesses can be found on the NHS Direct website:

Brain abscess is a serious disorder that occurs when micro-organisms such as bacteria or fungi get into the brain, causing inflammation. The bacteria or fungi, along with infected brain cells and pus, mass together in one area of the brain. They are joined by white blood cells that have been trying to fight the infection. The body's immune system responds by creating a membrane around this infected portion of the brain.

The swelling inside the brain can put pressure on delicate brain tissue and the mass of pus itself can block blood vessels that are supplying essential blood to parts of the brain. If prolonged, this can cause brain damage, because the oxygen supply to these tissues has been disrupted. It is therefore important to treat abscesses as early as possible. Medication is the first line of treatment.

Most brain abscesses occur when infection spreads to the brain from elsewhere in the body, mostly from nearby areas such as the ears. They can also be carried in the blood from further away areas of the body. Sometimes they are caused by head injuries or surgery.

Brain abscesses are very rare, but as long as they are treated before the person goes into a coma, nine out of ten people will survive.

Information obtained by the investigation team from the woman's own doctor shows that she last consulted him on 23 September. She complained that day about symptoms of headache and groin abscess. The doctor prescribed antibiotics and noted that the woman had said that her symptoms of headache had previously improved when taking antibiotics.

The woman's weight on arrival at Bronzefield was recorded as 67kg. At post mortem, her weight was recorded as 55kg. This suggests a very significant loss in weight of 12kg (26lbs). In its response to the draft version of this report, Bronzefield presented a number of persuasive arguments that suggest it likely that the woman's

weight on admission to Bronzefield was not 67kg, but was more probably 57kg. In accepting this explanation, criticism must be made about standards of clinical record keeping which is subject to separate criticism elsewhere in this report.

CONTACT WITH THE WOMAN'S FAMILY

The security manager at Bronzefield was informed that there was a medical emergency at about 12.30pm and he was given further information, including the identity of the prisoner, before the woman left for hospital. One of Bronzefield's nurses was at the hospital seeing another prisoner so the security manager asked her to keep him informed about the woman's condition. At 2.30pm, the security manager was told that the woman's condition was extremely serious and the hospital was requesting the attendance of her next-of-kin. The security manager was able to make telephone contact with the woman's partner and her sister, both of whom live in Sussex. They said that they would come to the hospital. After this, the security manager was also able to make contact with the woman's mother. At 6.30pm, the security manager was informed that the woman would not recover and that the hospital was awaiting the arrival of her family. The security manager then went to the hospital. When he arrived, he was told that the doctors wished to withdraw life support. After the security manager spoke to a nurse, the hospital agreed to delay the withdrawal of life support until the arrival of the woman's family. The woman's partner and sister arrived at 7.40pm and they were with her when she died at around 9.30pm.

The security manager paid for a taxi to take the woman's partner and sister back to Sussex. Bronzefield arranged a memorial service at the prison, which a number of the woman's family attended. The prison mini-bus collected her family from Sussex and took them back there after the service.

Bronzefield paid for the woman's funeral. The security manager represented the prison at the funeral service and organised the transfer of her property to her family.

FINDINGS AND CONCLUSIONS

When the woman was received into Bronzefield on 27 September 2006 she saw a nurse for the purpose of a first reception health screen. At this consultation the nurse recorded that in the recent past the woman had seen her doctor about two conditions – severe headache and an abscess in her groin. In answer to a separate question further on in the health screening form about physical health concerns, she said that she was concerned about her headaches. The woman supplied the name and address of her doctor.

On 28 September, a prison doctor, the GP, saw the woman. The GP recorded that the woman had a groin abscess, but his records contain no reference to headaches. At interview, the GP said that he had read the woman's first reception health screen form, but his practice was to ask open questions and the woman made no mention of headaches. While I acknowledge the value of open questions as a way of eliciting information, closed questions also have a value. I consider that the GP should have followed up his open questions by asking the woman specifically about her headaches. It may well be that she made no mention to the GP of that symptom, but her first reception health screen form contained two separate references to it.

During the consultation, the GP prescribed the woman medication for detoxification from opiates. The GP also prescribed antibiotics and an anti-inflammatory for the woman's groin abscess. There was no delay in the commencement of the woman's detoxification medicines, however six days passed before she began to receive her antibiotics.

Although the woman gave her consent for her doctor to release to Bronzefield information from her medical records, it would not seem that the doctor was contacted. Several other matters of concern were identified in the two clinical reviews obtained to consider this case. One matter was the recording of clinical observations. It is a Prison Service requirement that clinical observations should be recorded for at least the first 72 hours for those going through detoxification. Where there are complications, such as an abscess or headaches, these recordings should continue until the physical symptoms have resolved satisfactorily. In the woman's case, a few recordings were made of her blood pressure and pulse, but no recordings at all were made of her temperature. A high temperature (pyrexia) is a classic warning sign of infection, enabling clinicians to deliver appropriate care and treatment.

In her review of the woman's detoxification plan, the clinical reviewer has criticised aspects of the regime used and has also criticised the later addition to the regime of a night time sedative. The clinical reviewer is also critical of the standard of record keeping, referring to the lack of a care plan and the lack of contemporaneous nursing records.

Another matter identified in the clinical reviews relates to the overdose of antibiotics that the woman took on 4 October. The clinical reviewer points out in her report that only a very limited range of medicines, for instance asthma inhalers, should be issued in-possession during the detoxification period. Having

taken the overdose, an entry was made in the woman's records that she should not be reissued with in-possession medication. It is not clear if the woman was issued all of her medication during the following 36 hours or so. However, on 6 October, she was reissued with in-possession medication contrary to the explicit instruction recorded two days earlier.

The woman's friend said that the woman had been suffering with headaches and had told the officers about that. She had also been having 'drop fits'. One of the PCOs acknowledged that the woman had complained to him about headaches in the last two days of her life and he advised her to ask the nurses for painkillers. He had also witnessed her having a fit at this time and he thought that a nurse had come from healthcare. There is nothing in the woman's records to indicate that staff noticed any problems with her health.

The sequence of events as they unfolded through the night of 19 October, and as they continued through to midday on 20 October, make for disturbing reading. At about 10pm on 19 October, the woman rang her cell bell and told the night PCO that she had a bad headache and needed painkillers. The night PCO had never previously worked a night shift, so she asked another officer for advice on procedures and was told that nurses do not usually visit the wings at night for headaches. The night PCO passed this information to the woman. At around 5am on 20 October, she rang her cell bell again and told the night PCO that her head was really painful and the pain was also now running down the side of her body. The night PCO contacted healthcare and was told by the night nurse that the woman could not be given any medication at that time, as it would interfere with her morning medication.

When the SPCO came on duty in the morning he checked the wing observation book and saw an entry stating that the woman had been complaining all night about a bad migraine. The SPCO made arrangements to ensure that the woman was the first to be seen at the morning medication round. I commend the SPCO actions. While waiting to be seen, the woman was noted to be unsteady on her feet and was given a chair to sit on. The SPCO said that the medication nurse remained inside the medication room and she spoke to the woman through the medication hatch. This had surprised him.

There is a disparity between the evidence given by the SPCO and that given by the medication nurse. The medication nurse said that she did come out of the medication room and that she knelt in front of the woman to speak to her. Whether or not the medication nurse came out of the medication room, we do know that the medication nurse had difficulty in obtaining information from the woman and she asked the officer why she was not talking. The medication nurse gave two paracetamol tablets after the woman nodded her head to indicate that she would be able to swallow the tablets. The medication nurse explained to the interviewers that the only nursing support available to her at that time of the day was the 'response' nurse who has responsibility for dealing with emergency situations. The clinical reviewer considered that the woman's condition at this time was such that she should have been admitted to healthcare for observation.

After she had been seen by the medication nurse at around 8am, the woman went to her friend's cell and this friend was asked to keep a check on the woman. The woman's friend said that the woman was incontinent, her right arm was going numb and she was lapsing in and out of consciousness. She said that she spoke to the PCO and he said they were waiting for healthcare to come. The PCO told the investigation team that throughout the next few hours he kept going back and forth to the woman friend's cell to check on the woman (this is confirmed from the CCTV footage). He said that, although the woman was very drowsy, there was nothing about her condition to give him cause for concern. Nor did the woman's friend say to him that she was concerned.

At about 10.30am, a pre-arranged fire drill took place and prisoners were taken to a small courtyard. The woman was unsteady on her feet and was escorted to the yard by two of the prisoners. When they reached the yard, she sat down on a low concrete plinth. Staff and prisoners became concerned about her condition, so healthcare were contacted. The healthcare nurse came to see the woman and decided she should take her to the healthcare unit. The healthcare nurse did not consider that the situation was serious at that time. When they arrived in healthcare, the healthcare nurse recorded the woman's pulse and blood pressure and checked her eyes. The healthcare nurse told the woman to rest and said she would return later to check on her. The healthcare nurse was still not concerned at that stage. It was when the healthcare nurse returned to see the woman at around midday that she realised that the situation might be serious and she called the GP. With very little further delay, an ambulance was called and the woman was rushed to hospital. When she reached hospital, it seems to have become clear fairly quickly that she would not survive.

The woman died from cerebral compression caused by a brain abscess. The clinical reviewer points out in her report that, although a rare condition, brain abscess is a known complication that can arise from injecting drug use. In the woman's case, opportunities were missed that might have had an impact upon the ultimate outcome:

- When she first arrived in Bronzefield the woman reported that she had recently consulted her doctor about a groin abscess and about headaches. Despite this recent clinical history, the woman's doctor was not contacted and her medical records were not obtained. PSO 3050, issued in February 2006, advises that efforts should be made to obtain the records from doctors or other relevant services with whom the prisoner has been in recent contact.
- The woman also reported on that first day that she was concerned about headaches, but this report was not explored.
- The woman was prescribed antibiotics for her groin abscess on 28 September, but six days passed before the antibiotics were issued by the prison pharmacy.
- The woman's clinical observations should have been recorded for at least the first 72 hours, but her temperature was never recorded and so this possible warning sign of an infection was missed.

- Finally, the woman began complaining of a severe headache from around 10pm on 19 October. She complained again at around 5am the following morning and at around 8am she was observed to be unsteady on her feet so a chair was brought for her to sit on. When the medication nurse tried to speak to the woman, she was minimally responsive. Despite these obvious signs that morning that the woman was unwell, three hours had passed before she was taken to healthcare and it was a further hour before an ambulance was called to take her to outside hospital.

RECOMMENDATIONS

I make the following recommendations which are based upon the clinical reviews obtained in this case.

In response to early disclosure of an interim draft of this report, UKDS responded with comments on existing practices or action since taken in relation to specific recommendations. Comments from UKDS appear below the relevant recommendation.

HEALTHCARE AT BRONZEFIELD

1. The PCT, in partnership with the Director, must undertake a health needs assessment of the local primary and secondary care services for female prisoners at Bronzefield. This must include considering the next steps to address the identified learning from this investigation and an action plan to meet them.

Recommendation accepted.

The PCT have confirmed that a Health Need Assessment will be carried out at the prison starting July 2006.

HEALTH SCREENING

2. Where a prisoner presents with any previous medical history or reports that they are receiving prescribed medication, information regarding medical history and current prescribing must be obtained from the GP or hospital.

2.1. Where a medical history is requested but does not arrive, this must be pursued until the information is obtained.

2.2. Where there have been previous admissions to prison, the medical record for the past periods in custody must be obtained.

Recommendation accepted.

Response from UKDS: It is now the practice of the nurses in the out patients service to contact the prisoner's GP within 24 hours of arriving at the prison for those whom this is deemed necessary.

It is already the practice of the nurses in the outpatient's service to contact the prisoner's GP within 24 hours of arriving at the prison for those for whom this is deemed necessary. A monitoring system is now in place which includes regular chasing of non received information. This is not to say, however, that every set of notes should be obtained. The

need for clinical records is a decision that should remain with the lead clinician.

Archived medical records are now kept with the core records and are retrieved each time a prisoner returns to the prison. The medical in confidence guidelines are still maintained, however this does ensure that previous medical records are available to healthcare staff as soon as possible.

3. The First Health Reception Screen form should be used to inform subsequent clinical consultations. All physical, psychological and drug related health issues declared on the form must be discussed with the prisoner and further clinical information obtained to enable an appropriate management plan, including clinical tests and treatment to be developed.

Recommendation accepted.

4. A pregnancy test must be undertaken for all women of child bearing age with the result being entered in the medical records.

Recommendation partially accepted locally.

Whilst this cannot be enforced, a pregnancy test is offered to all on reception with decisions to refuse recorded.

CLINICAL SUBSTANCE MISUSE

5. HMP Bronzefield must fully review their drug service provision in line with the Drug Treatment Services Guide and the identified learning from this investigation, including the two specialist reports, and develop an action plan to address the identified issues.

Recommendation accepted.

UKDS have recently met with a specialist and the Head of Health and Offender Partnerships to explore a service which links more closely to the Drugs Treatment Service Guide. As a result of this meeting the specialist will be assisting all UKDS prisons with a review of the current drug service provision and will work in partnership with the UKDS Healthcare Advisor to agree changes to promote a closer working relationship.

MEDICATION

6. Other than in the case of exceptional circumstances, medication must be issued and dispensed on the day it is prescribed. The Director might wish to investigate the reasons for the six day delay in the woman being issued her prescribed antibiotics.

Recommendation accepted.

We are investigating the circumstances which led to the delay, and will act on any outcomes.

7. Medication (other than asthma inhalers and topical creams) should not be given in-possession during the withdrawal phase.

Recommendation accepted.

This will be incorporated into the review referred to under recommendation 5.

8. An overdose in custody can be a contra-indication for issue of in-possession medication. Where a prisoner has taken an overdose, an appropriate risk assessment should be carried out with that individual before issuing further in-possession medication.

Recommendation accepted.

Response from UKDS: This is current practice.

9. The use of Tricyclic anti-depressants for sedative effect at night must be reviewed.

Recommendation accepted.

Response from UKDS: The Head of Healthcare and the UKDS Medical Adviser will undertake a review of the use of Tricyclic anti-depressants for sedative effect at night.

RECORDS/RECORD-KEEPING/COMMUNICATION

10. Baseline clinical observations of temperature, pulse and blood pressure must be undertaken on every new admission requiring clinical substance misuse management for at least the first 72 hours as indicated in PSO 3550. Any abnormalities in temperature or blood pressure recordings should be monitored until stable for a period of several days and the patient reviewed by a doctor.

Recommendation accepted.

This will be incorporated into the review referred to under recommendation 5.

11. Where there is any concurrent infection in a patient, or other symptoms such as headache or fainting, clinical observations must be monitored until the physical symptoms resolve.

Recommendation accepted.

Response from UKDS: All healthcare staff will be reminded of the need to monitor prisoners with the described symptoms. This will also be reinforced in the nurses/healthcare assistants training programme.

12. Any persistent complaint of a headache should be viewed as potentially serious and monitored and/or assessed. If there are other presenting symptoms, or the headache is unusually severe, or persists over a protracted period, assessment in outside hospital must be arranged.

Recommendation accepted.

Response from UKDS: This will be put on the agenda of the next Clinical Governance meeting to be discussed with the lead GP.

13. An audit of record keeping practices at Bronzefield against Nursing and Midwifery Council (NMC) and General Medical Council (GMC) standards should be undertaken. It should include the use of contemporaneous nursing records and care plans for the acute period of stabilisation and for a prolonged period where concurrent physical symptoms persist. Language used in medical and nursing records should be respectful and demonstrate empathy.

Recommendation accepted.

Response from UKDS: This has already been planned.

14. Communication between the members of the healthcare team should be encouraged. Multidisciplinary team meetings and discussions should be considered as this would improve continuity of care. Communication between multidisciplinary staff needs to be addressed as a matter of urgency and should abide by the principles set out in the Nursing and Midwifery Council's code of professional conduct.

Recommendation accepted.

Response from UKDS: The healthcare department holds weekly care plan meetings. Action can be taken by healthcare staff in the interim periods as required after assessment.

SELF-HARM

15. The Director must arrange introduction of a policy for caring for, and for the clinical monitoring of, patients who have taken an overdose. The policy must include both the physical assessment and psychological support aspects of care and should reflect the local suicide and self-harm policy and must be communicated to all healthcare staff.

Recommendation accepted.

Response from UKDS: The healthcare department has an in-possession risk assessment currently in place. A protocol for the treatment of a prisoner who takes an overdose has now been completed.

CONTINUOUS PROFESSIONAL DEVELOPMENT

16. The Director must ensure that a policies and procedures manual is available in a hard copy and electronic format for all staff. Healthcare staff must be reminded to follow policy at all times and should ensure that they remain up-to-date in accordance with the NMC code of professional conduct.

Recommendation accepted.

Response from UKDS: Each member of the healthcare team will be issued with a personal copy of the policies and procedures relating to healthcare, with a copy to be held centrally. Policy reviews will be considered at Clinical Governance meetings with revised policies disseminated for individual update. Training on policies will also form part of the healthcare training programme.

17. A professional training and development needs analysis must be carried out to identify the training needs of all staff working in healthcare.

Recommendation accepted.

Response from UKDS: This has already been started and will be completed shortly.

18. Staff on professional registers must be reminded that they have a personal responsibility to maintain their continued professional development.

We recall this was discussed with the Deputy Ombudsman at the time of her visit. The Deputy Ombudsman advised that this was indeed a general comment, which refers to the actions or a few individual nurses and was not referring to the entire healthcare staff. It was meant to suggest that it is always useful to have reminders to any nursing group.

The Head of Healthcare already has this as part of her ongoing clinical supervision of the department.

19. Staff on professional registers must be reminded that they have a personal responsibility to adhere to the standards set out by their professional bodies in relation to patient care. For instance the requirement that staff should understand and work within the limits of their competency.

(See response to recommendation 18)

20. Prison Custody Officers should receive an induction on night time procedures before carrying out a night shift.

Recommendation accepted.

Response from UKDS: The Head of Healthcare already has this as part of her ongoing clinical supervision of the department.

A review of the Local Operating Policy covering night procedures has already taken place and has been distributed to all staff. The night orderly officer will additionally brief any new member of night staff.