

**Investigation into the death of a woman
at HMP Holloway in December 2007**

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

July 2009

This is the report of an investigation into the circumstances surrounding the death of a woman. She was found dead shortly before 7.00am on 10 December in her bed on the detoxification unit at HMP Holloway. It was her first time in custody and she had been in the prison only 36 hours. A Post Mortem and two toxicology reports have so far failed to find a cause of death.

The woman was a young person who had struggled with substance misuse following the breakdown of a relationship. She leaves a caring family and a young daughter. The day before she died she spoke at length about her daughter and how she wanted to go home to her family. I would like to offer my sincere condolences to the woman's family and friends. It is a tragedy to lose someone so young. It must be especially difficult when there is no apparent explanation for why she died.

The investigation was led by one of my investigators. Both she and my senior family liaison officer met the woman's family during the course of our enquiries. In addition, an independent review into her medical care was undertaken by the Primary Care Development Lead (substance misuse) for the PCT. I am grateful to her for her assistance. I am also grateful to the prison liaison and to the staff and prisoners at Holloway for their co-operation with this investigation.

I have raised a number of concerns about the care offered to the woman at Holloway, and have made several recommendations including a full review of detoxification and withdrawal monitoring. The investigation has found that there is a strong incentive to women to lie about their alcohol use in order to obtain medication to tide them over withdrawal from opiates. I am also concerned that several of my recommendations echo those I made after the death of another woman at Holloway in 2005. Nevertheless, the cause of the woman's death remains unexplained and there is no certainty that the care she received at Holloway contributed in any way to it.

My report was issued by advanced disclosure to the Prison Service in July 2008 and they responded with an action plan on 21 July 2008. All recommendations were accepted and I have reproduced the response to them in the recommendation section. The woman's family responded in April 2009 and asked for no changes to be made. Although a whole year has passed between the issue of the draft and final reports, the prison service and the family were made aware of the contents at an early stage.

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Prisons and Probation Ombudsman

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SUMMARY

The woman was still a young person when she died. She had been arrested at her home shortly after 7.00am on Saturday 8 December 2007 and taken to the Magistrates Court. She was charged with shoplifting and two counts of failure to appear in court. She was remanded into custody at HMP Holloway pending a further court appearance on Monday 10 December. It was her first time in custody.

The woman arrived at Holloway at about 4.00pm. A nurse completed a New Patient Health Check and a doctor assessed her in reception. The reception doctor diagnosed her as opiate and alcohol dependent. He prescribed buprenorphine and chlordiazepoxide in accordance with Holloway's local substance misuse protocols. From subsequent comments from other prisoners and the woman's family, it appears that she greatly exaggerated her alcohol consumption at this interview. The assessment by the reception doctor is a 'triage' assessment. Patients are normally reassessed by a specialist doctor on the detoxification unit (H1) the next day. The specialist doctor on H1 works Monday to Friday. Prisoners arriving at Holloway on Friday evenings and over the weekend are not reassessed until Monday morning.

On H1 the woman had a urine test that showed a positive result for morphine and cocaine. It also showed she had a urinary tract infection. She was allocated a bed in dormitory room 18 with three other women. She began her alcohol detoxification medication that night. Opiate detoxification medication is not given on the first night in Holloway. At about 3.00am, night staff were alerted to a disturbance in room 18. Discipline officers were called and it was decided she should be moved to another room. Although she did not say much about what had happened, staff thought she had been hit by two other women.

The next day, the woman's clinical observations showed that she had a temperature. She took her morning medication but vomited after being given her first buprenorphine dose. She was given an injection of metaclopramide for her nausea. At about 2.30pm, it was discovered that she had kept some tablets back from her afternoon medication. She was searched and an empty chlordiazepoxide capsule and a white powder were recovered from her room. Two women in her room said that they had seen her snort the contents of two chlordiazepoxide capsules before and after she was searched by staff. Despite staff being made aware of this, she was not searched again. Her baseline observations (temperature, blood pressure and pulse) were taken which showed her temperature had gone up. The local withdrawal monitoring tool was not completed.

The woman continued to vomit during the afternoon and early evening. At 7.00pm, another nurse gave her another metaclopramide injection. The woman's cell mates reported that she was very ill throughout Sunday 9 December but staff interviewed did not think she looked any more unwell than most people on their first day of detoxification.

The woman took her evening dose of alcohol detoxification medication and an oral dose of metaclopramide. One of the cell mates in her room said the woman was making 'snorting' sounds in the night but reported that she had sat up in bed at

3.00am and smiled at her. Shortly before 7.00am the next morning, the woman was found dead in bed.

A Post Mortem report said that the woman's death was consistent with Sudden Adult Death Syndrome. The toxicology results showed a history of drug misuse but no evidence of fatal intoxication. At the time of writing the Coroner is considering commissioning a further specialist review.

I raise concerns about the assessment and reassessment of women on H1 at the weekend. I make nine recommendations including a review of all the detoxification procedures and withdrawal monitoring on H1.

THE INVESTIGATION PROCESS

1. I was notified of the woman's death on the day she was discovered (10 December 2007). The investigation was allocated to one of my senior investigators on 11 December. Notices were issued to staff and prisoners at Holloway telling them that an investigation would be taking place, and inviting those who wished to see the investigator to make themselves known. My investigator wrote to the Coroner and spoke to a CID Detective Sergeant.
2. My investigator visited Holloway on 18 December 2007. She met the Head of Security, and Deputy Governor. My investigator interviewed three prisoners and collected copies of the woman's prison record and copies of other records associated with her death.
3. A clinical review of the woman's medical care was commissioned from the Primary Care Trust (PCT). The review was undertaken by the Primary Care Development Lead for substance misuse.
4. My investigator returned to Holloway on seven occasions in January, February and March 2008 and interviewed 16 members of staff. She also re-interviewed two of the three prisoners interviewed in December 2007. Interviews with the clinical staff were undertaken jointly with the clinical reviewer. My investigator and the clinical reviewer also spoke informally to the Healthcare Operations and Drugs Strategy Manager, the Deputy Clinical Services Manager, the prison's lead GP and the doctor on H1.
5. My investigator spoke to a member of staff from the Medical Toxicology Laboratory at Guy's and St Thomas's Hospital Trust. He explained the results of the toxicology tests.
6. My senior family liaison officer contacted the woman's mother and father by telephone. She and my investigator visited the woman's parents and aunt to hear their questions and concerns. Regular contact was maintained with the family throughout the investigation.

HMP HOLLOWAY

7. HMP Holloway is a women's local prison in North London. It has an operational capacity of 493 adults and young offenders. In the last three years the population profile has changed significantly as HMP Bullwood Hall and HMP Cookham Wood have stopped taking female prisoners. The average population figures for March 2008 recorded 151 sentenced adults, 167 sentenced young offenders, 134 unconvicted adults and 15 unsentenced young offenders. The majority of women (over 60 per cent) arriving at Holloway suffer from alcohol and drug dependency and require some form of detoxification.
8. Historically, Holloway was the first prison to offer detoxification provision in 1997. By 2004, over 8,000 women across England were managed in local prisons using protocols and practice initiated and developed at Holloway.

Ivor Ward Unit (H1 and D1 landings)

9. The Ivor Ward Unit (H1 and D1) was opened in August 2006 and is the prison's dedicated detoxification unit. H1 is the detoxification landing and holds up to 40 women. There are a further 19 beds on D1 landing which is the post-detoxification landing. Staff on duty cover both landings. There are some single cells but most women share dormitories of four. Women stay on the unit for varying lengths of time depending on their treatment and are only moved to the main prison after assessment. In the mornings there are four nurses and a healthcare assistant (HCA – a non-qualified member of staff) on duty, supported by three discipline officers. Four nurses and one HCA is the minimum number required to be able to dispense morning medication and undertake clinical observations. In the afternoon there are three nurses and a healthcare assistant supported by discipline staff. One of the nurses goes off duty at about 6.00pm. During the day the clinical staff on H1 and D1 are supported by a senior officer and three officers. At night the unit is staffed by a single nurse and a single HCA who come on duty at 9.15pm. Evening medication is given through hatches in the cell doors. The night nurse and HCA carry a cell key in a sealed pouch but, except in a medical emergency, are required to call discipline staff if they need to open a cell door at night. (The prison is run by a night orderly officer. There are four response officers designated to respond to any calls.)
10. At the time of writing Holloway is four nurses below complement and the prison relies on staff working on over-time and agency staff to cover shifts. The unit has its own doctor who works Mondays to Fridays. Women who are opiate dependent are mostly given Subutex (buprenorphine) in crushed tablet form. Staff commented to my investigator that the unit has been much calmer and quieter since the introduction of Subutex.
11. In July 2004, Holloway began replacing some of its paper medical records with an electronic record system called EMIS. The New Patient Health Check undertaken by a nurse and the reception doctor's assessment are set up on EMIS in template form. The continuous clinical record, where daily events and interventions are recorded, is also on EMIS. Other records such as the

withdrawal monitoring chart and individual care plans are paper based. EMIS is only accessible by clinical staff. Occurrences that both clinical and discipline staff need to be aware of are recorded in the wing observation book which is kept in the main office on H1.

THE EVENTS LEADING UP TO THE WOMAN'S DEATH

12. The woman was arrested at her home shortly after 7.00am on Saturday December 8 2007. She was taken to the Magistrates' Court where she was remanded into custody on a charge of theft, pending a further appearance on Monday 10 December. She was taken to HMP Holloway and arrived at about 4.00pm.
13. On arrival at Holloway, the woman was taken to Reception. On all of her prison records her first name was incorrectly spelt, despite being recorded correctly on her warrant. Her property was checked and listed. An officer completed a cell sharing risk assessment form and concluded that she presented a low risk of sharing a cell. The record shows that she said that she was dependent on drugs and alcohol. She signed various prison compacts (agreements to abide by prison rules) and was given her prison ID card.
14. At 4.17pm on 8 December an Inmate Medical Record (IMR) on EMIS was opened for the woman. Some time after this she was interviewed by a nurse, whose role is to complete an initial health screen using the New Patient Health Check template. He makes a note of any outstanding issues and offers the women the opportunity to be vaccinated against hepatitis. He takes initial observations including blood pressure and records height and weight. The reception nurse told my investigator he does not speak to the women for very long as reception is busy and he is under pressure to move them through the system. He said that if he has any concerns about someone he will tell the reception doctor. The reception nurse remembered the woman and described her as "bubbly". He did not have any concerns about her during their interview. He transfers the information he gathers during the New Patient Health Check onto EMIS as soon as possible. In this case he entered the woman's details at 5.35pm.
15. All new arrivals are also assessed by the reception doctor. The woman was assessed by the reception doctor at 5.14pm. The assessment follows a template on EMIS and takes about 15 minutes. The doctor concluded that the woman was dependent on opioids, crack cocaine and alcohol. The doctor observed that the woman seemed "positive except withdrawing" and had no thoughts of deliberate self-harm. He prescribed chlordiazepoxide (librium; for the symptoms of alcohol withdrawal), Buscopan (for stomach cramps), Ibuprofen, metaclopramide (Maxolon; for nausea), vitamin B supplements and buprenorphine (Subutex; for opiate withdrawal). The doctor referred her to the doctor and drugs service for help with her substance misuse. He assessed that she was fit for normal location, work and sharing a cell.
16. At 7.05pm, the woman was admitted to H1. She was interviewed by a H1 nurse who entered some basic information on to EMIS. The woman was taken to a separate room for a urine test. The urine test is a 'dip and read' test. It tests for the presence of drugs but does not specify the levels present. There is no equipment for testing for the presence of alcohol. The EMIS record shows that the H1 nurse recorded that the woman's urine test showed positive results for cocaine and morphine at 7.41pm. The H1 nurse does not remember

entering this data and said she thought that the HCA who took the urine test probably entered the results on EMIS using her log-on information.

17. The woman was located in dormitory room 18 with three other women. At interview, one of her room mates said that she had seen the woman at court earlier that day. She said court staff had asked her whether they could put the woman in her cell as she had become distressed. The room mate said that this had not happened but she had been in the same van as her when they were transferred from the court to Holloway. The room mate said that, when she was located on H1, she asked whether the woman could be put in her dormitory because she thought it might help her to see a familiar face. When she came to the dormitory she went to sleep at about 9.30pm. The room mate said she thought this was odd because, in her experience, people who are withdrawing are normally wide-awake and cannot sit still.
18. The room mate said that, at about 3.00am on 9 December, the woman woke up and pressed the cell bell to ask the nurse for some hot water. The room mate said the woman then asked her in "quite a rude way" to make her a cup of tea. This led to a fight between the woman and another prisoner. The room mate said she tried to separate the two women but they continued fighting and night staff came into the cell.
19. The HCA told my investigator that shortly before 3.00am she answered the cell bell for room 18 and the other prisoner asked her for some hot water. As she walked away from the cell she heard a scuffle and shouting. She went back to the cell hatch and asked what was going on. She said the room mate told her that the woman had asked them to make her a cup of tea. When the HCA returned with the hot water she saw the woman lying on her bed and the room mate and other prisoner were "very agitated and shouting". The HCA told her nursing colleague that she thought there had been a fight and the nursing colleague used her radio to call for discipline staff.
20. The HCA returned to room 18 with her nursing colleague and saw the woman sitting on her bed looking "ashen" with the room mate screaming at her. An officer said she and a colleague were in the office on H1 when they heard the call on the radio for assistance. They walked around the corner and saw the two night staff standing outside room 18. The H1 officer unlocked the cell door. The woman was sitting on her bed facing the door and avoiding eye contact with the other women in the room. The H1 officer asked her if she was okay but she did not reply. She noticed some blood around her nostril. The H1 officer said staff decided to move her to another room and the HCA took her to the office while this was organised. The HCA made her a cup of tea. She noticed blood on the woman's night dress and moved her hair to check where it had come from. She said to her, "They've hit you haven't they?" and she replied that they had.
21. The H1 officer made an entry in the wing observation book and the woman's wing history sheet. A F213 Report of Injury to Inmate (female) was completed and the nursing colleague made an entry in her EMIS record.

22. There were no single rooms available and the woman was moved to dormitory room 28. Room 28 was occupied by three other women. One of the occupants told my investigator that the woman had been tearful and upset when she came into the room and told her that she had been bullied in her previous room.
23. In the morning the women are unlocked at about 8.00am to collect their breakfasts. They return to their rooms to eat and then are unlocked in sequence to receive their morning medication. Clinical observations such as blood pressure and temperature are taken by a HCA. The HCA completes a withdrawal monitoring form. This is a standard template that contains questions about how the person is feeling. It is completed every morning for the first three days (72 hours) of detoxification. If the HCA has any concerns about someone they tell the nurses in the medication room next door. The women then queue outside the medication room and receive their medication through a hatch. There are two nurses in the medication room. An officer stands by the hatch and gives the women water to take their tablets. The officer checks the women's mouths to make sure they have swallowed the tablets. Those women undergoing buprenorphine detoxification then go to a separate room where another two nurses give them their dose.
24. The woman's IMR shows she had a temperature of 37.8C on Sunday morning which indicates pyrexia (raised temperature – the normal range is between 36.6 and 37C). Her withdrawal monitoring chart for 9 December shows that she said she was experiencing, nausea/vomiting, stomach cramps, fluctuation of mood, tremors/shakes, unsteady gait, diarrhoea, runny nose, drowsiness, agitation/restlessness and disturbed behaviour. On a scale of nil to three, with one being mild and three being severe, the woman said she was experiencing all of these symptoms mildly. She then went to the medication room hatch where she was given her morning dose of chlordiazepoxide, metaclopramide, Buscopan, Ibuprofen and B vitamins. A medication room nurse told my investigator she remembered the woman had a high temperature and gave her some paracetamol. She said she wrote the woman's name on a piece of paper to indicate that, in the light of her high temperature, she should have her observations taken again before afternoon medication.
25. Another nurse was on duty dispensing buprenorphine on the morning of 9 December. In interview, the dispensing nurse said that the woman vomited twice while being given her buprenorphine. The dispensing nurse took her back to her room and gave her an intra-muscular injection of 10mg of metaclopramide for her vomiting. She estimated that this was at about 10.45am. The dispensing nurse recorded this on EMIS retrospectively at 2.50pm.
26. At 10.30am, a senior officer (SO) began interviewing the woman, the other prisoner and the room mate about the incident in room 18. She interviewed each woman alone as part of a cell sharing risk assessment review. In interview, the SO remembered that the woman appeared to be having a bad withdrawal and was very jumpy and twitchy. The woman said that the other prisoner and the room mate had both hit her. The SO said the woman presented as someone who did not want to get into trouble. The SO asked the

woman what was happening to her. She said that she was going to court on Monday and expected to be released and to go home to her family. The SO said the woman talked about her little girl and said on several occasions that she wanted to go back to her family. She told the SO that it was her first time in prison and she wanted it to be her last. They discussed her drug use. The SO said the woman was quite alert during her interview and gave careful consideration to her answers.

27. The medication room nurse told my investigator she answered a cell bell from room 28 between 12.30 and 1.30pm. The cell bell call record shows a call at 1.00pm that was answered within a minute. The nurse said the woman told her that she had vomited her morning medication and asked for another dose. She particularly asked for another dose of chlordiazepoxide. The nurse told her that she could not have any more withdrawal medication as she was being sick. She told her that she would have another dose at afternoon medication. The nurse thinks she gave her an oral dose of metaclopramide. This conversation was not entered on EMIS. If the nurse did give the woman an oral dose of metaclopramide, she did not record it on the drug administration chart.
28. Afternoon medication is usually dispensed between 2.30pm and 3.00pm. The women are again unlocked in sequence and get their medication from the hatch outside the medication room. The woman would have received her dose of chlordiazepoxide, metaclopramide, Buscopan, Ibuprofen and B vitamins all in capsule form. Depending on how the dose of chlordiazepoxide was split (it comes in 5mg or 10mg capsules and she was prescribed 25mg three times a day), this would mean she had up to 15 capsules to take.
29. An officer was on duty in the afternoon of 9 December giving the women water and checking their mouths to make sure they had swallowed their medication. She told my investigator she checked the woman's mouth and thought it was empty. As the woman left the queue and walked back to room 28, another woman in the queue said to the officer on duty, "Miss, she's concealed something." The officer on duty said she asked another officer to take over her duties and followed the woman back to her room. As she approached room 28, the officer on duty noticed that the hatch in the door was closed, which was unusual. The officer on duty said she waited for a few seconds and then pushed open the door. She noticed that all three of the other occupants were present in the room. She saw the woman sitting facing her bedside cabinet leaning over a green towel with white powder on it.
30. The officer on duty said that as soon as the woman saw her she leapt to her feet and "her hands went everywhere" including down her trousers. The officer on duty said she went over to her and held her hands up in the air. She called to other staff for assistance. The officer on duty remembered a female colleague entering the room and asking the other women to leave. The officers then placed a blanket over the door to stop anyone looking in, and strip searched the woman. No other substances were found during the search.
31. The officer on duty said she and her female colleague sat and chatted to the woman after the search. She said the woman was nervous and shaking. The

officer on duty said she explained that H1 was a detoxification unit and prisoners were not allowed to keep their own medication. She said the woman told her that she would not do it again and said, "No, no I've been silly, I'll behave." The officer on duty said she asked her whether she had anything else concealed and she said she had not. Because of the fight the previous night, the officer on duty asked the woman whether she was concealing medication for anyone else. She again said she was not. The officer on duty said at interview that she was not aware that the woman had been vomiting during Sunday 9 December. She said she did not appear to be any more unwell than any of the other women on H1.

32. Another officer, on duty at the medication room hatch said at interview that, at about 2.30pm, he was observing afternoon medication. As the woman passed him another prisoner in the queue said, "Sir, she's kept something back." The officer said he called her back and asked her to open her hands and her mouth. She had nothing in her hands and he could not see anything in her mouth. He said the woman went back to room 28 and he went to find the officer on duty and her female colleague to search her. He later learned that a capsule had been recovered during the search.
33. The female colleague said the woman did not look any more unwell than any prisoner going through detoxification. She thought the woman "carried herself quite well" considering it was her first time in prison. She said she chatted to the woman and found her to be completely coherent. She was not slurring her words. She did not think she was struggling or desperate. The woman was compliant throughout the search and did not seem "fazed" when informed she would be placed on report (prisoners are placed on report if they break prison rules). The female colleague made an entry in the wing observation book and in the woman's wing history sheet. She completed a chain of custody form (a record showing the disposition of evidence) for the empty capsule and the white powder. Another nurse identified the capsule as chlordiazepoxide.
34. The dispensing nurse took the woman's temperature, blood pressure and pulse after the search and the other nurse entered the results on her chart. The woman's IMR shows that the readings were taken at 3.45pm. Her temperature was recorded as 38C. The other nurse did not complete the withdrawal monitoring chart. At interview, she said this was because she would have had to fill in the 'Day 2' column and it was not day two.
35. One of the room mates in room 28 said that during the afternoon the woman "snorted" the contents of her chlordiazepoxide capsule and this made her sick and drowsy. She said the capsule was medication that the woman had been given that afternoon. She said that staff carried out a search of their cell, but after they had gone the woman produced another chlordiazepoxide capsule and again snorted the contents. Two of the room mates in room 28 told my interviewer that they told the officer on duty, and the other officer on duty at the medication room hatch that the woman had snorted another capsule after the search.

36. The other officer on duty at the medication room hatch said that during the afternoon the second room mate in room 28 told him that the woman had “gone and snorted something else”. The officer said he did not do anything in response to this information and he did not consider moving her to a single cell because H1 was full. The first room mate in room 28 told him that the woman had vomited bile onto the floor of the cell. One of the other women in the room told him that she had been trying to make herself sick. The first room mate in room 28 volunteered to clear up the vomit. The other officer on duty at the medication room hatch said he told one of the nurses on duty that the woman had been sick. The officer said he remembered seeing her collecting her teatime meal and thought she was looking “okay”. The officer on duty could not remember anyone telling her that the woman had snorted the contents of another capsule.
37. The other nurse told the investigator that later in the shift the female colleague told her that the woman was vomiting. The officer on duty collected a metaclopramide ampoule and her female colleague unlocked her room. The other nurse knew the woman had already had an injection that morning so she asked her on which side it had been given. The other nurse then gave her an injection of metaclopramide in her other side. She said she was talking coherently and seemed well. The other nurse recorded this incident on EMIS retrospectively at 9.10pm. She recorded that she was sick at about 6.55pm and the injection was given at 7.00pm.
38. The other nurse said she did not make any further checks on the woman because she was not worried about her. At about 8.00pm a woman in room 26 pressed her bell. On the way back the other nurse passed room 28 and the woman asked her if she could have another injection. The other nurse said she would mention it to the night nurse. She remembered mentioning the woman to the night staff as soon as they came on duty, and she recalled the HCA going to see the woman straight away.
39. The HCA said she came on duty at 9.15pm. She was told at hand-over that the woman had been given an injection for nausea and had been found with a substance. She went to see her and spoke to her. She said she was lying on her bed and did not seem unwell. At evening medication the woman was given chlordiazepoxide, an oral dose of metaclopramide, Buscopan and Ibuprofen. The nursing colleague said she made a particular point of speaking to the woman when she gave out her medication. She asked if she had been in prison before and they shared a joke. The nursing colleague said the woman did not appear unwell.
40. The HCA said that a woman in room 25 had to be checked every 15 minutes that night, and she therefore went past room 28 frequently during her duty. She did not notice anything untoward in room 28. She said the first room mate in room 28 had toothache that night and she spoke to her on a few occasions and gave her hot water and painkillers. Just before 5.00am, she told the first room mate in room 28 she was about to wake the women who were going to court. The first room mate told her that the woman was due to go to court. The HCA said the woman’s name was not on the list. The first room mate said that the

woman had woken up at about 3.00am, sat up in bed and smiled and said, "I'm going to court today."

41. The first room mate said that she was awake most of the night because she had toothache. She said she spoke to the woman in the night and she told her that she was hot. The first room mate said she touched the woman and she felt really hot. She was sweating a lot and she took her blanket off to try to cool her down.
42. The HCA said that not long before 7.00am she received a telephone call from the control room telling her that the woman was due to go to court that morning. The HCA went to room 28 and saw the woman in bed lying on her back. She called out to her but got no response. As the first room mate was awake, the HCA asked her to wake the woman. The first room mate went over to the woman and then screamed and said, "Her eyes are open and she's not breathing." The HCA ran to the office and told the nursing colleague. The nursing colleague told her to call for the discipline staff and ran to room 28. Just then the medication room nurse arrived on the unit and they all went to room 28. The medication room nurse used her keys to enter the room. Both nurses said they thought the woman was already dead. Despite this they started cardio pulmonary resuscitation (CPR) and continued until the ambulance arrived. The HCA took the other women down to the TV room and made them all a hot drink.

THE PRISON'S RESPONSE TO THE WOMAN'S DEATH

43. The incident log shows that the emergency call from H1 was made at 6.47am. The call was received in the control room by telephone. Three officers responded. The orderly officer called an ambulance at 6.49am and made her way to H1 where she took over writing the incident log from one of the officers. The ambulance staff arrived on H1 at 7.10am. The paramedics declared the woman dead and did not make further attempts to resuscitate her.
44. The first room mate in room 28 told the investigator that she, and her other room mates were given a hot drink and some tobacco in the TV room. They were then moved to a dormitory room in the segregation unit. Later the same day they were moved back to H1 and put in single cells. The first room mate said she was told this was because the police had asked that they be kept apart. When she spoke to the police on 14 December, they denied this. She said she did not have access to showers or exercise during these three days. The first room mate said she had spoken to the Governor, and been offered access to the Samaritans phone (a cordless telephone on which prisoners can speak to a Samaritan) and the chaplaincy while in the segregation unit. She said she had not been offered support on her return to H1.
45. The second room mate in room 28 said she and the other first room mates had been taken to the segregation unit together. Before the end of the day they were returned to H1 and put in single cells. She said she remained locked in her cell until the police interviewed her on 14 December. She was told the police had asked that she be isolated until interviewed. She said that, apart from the SO, no one had offered her any support in the aftermath of the woman's death.
46. All the relevant agencies were notified of the woman's death in a timely manner. The Governor chaired a hot debrief later the same morning. The staff who attended reported that they felt well supported.
47. The police broke the news of the woman's death to her parents later the same day. When they visited the address the woman had given for her mother, there was no one at home. They later visited her father. The woman's father said the police gave him the Governor's phone number and he called her. The woman's mother and aunt visited H1 the next day. They met the Governor and other senior staff. The SO showed them around H1 and they spent some time alone in room 28. The Governor and three other members of staff attended the woman's funeral.

WHAT OTHER PRISONERS SAID

48. Two of the room mates, in room 28 told my investigator that the woman was unwell on Sunday 9 December. The first room mate said that she thought that the woman had appeared to be “under-medicated” when she got to know her on Sunday morning. As the day progressed she thought that she appeared to be “over-medicated”.
49. The first room mate said that on Sunday morning she thought the woman was experiencing a normal heroin ‘cluck’ (prison slang for the symptoms of withdrawal). She was agitated and her legs were kicking. The first room mate thought that the woman deteriorated throughout the day, and by the evening she said she appeared drowsy and kept falling in and out of a deep sleep. When she was in the deep sleep she was breathing strangely. The first room mate did not think this was the sort of sleep brought on by withdrawal from crack cocaine. Also by the evening the woman’s speech was quite slurred, and she was not as restless as she had appeared in the morning. The first room mate said the woman vomited on a number of occasions throughout the day. She said she was sick every time she had a drink of water.
50. The first room mate said she thought the woman’s symptoms were of illness rather than the sort of symptoms brought on by withdrawal and detoxification. She said that the woman had told her that she was not an alcoholic, but had been told by another prisoner in reception to tell staff she was so that she would be prescribed more drugs. She had two injections to stop her being sick but these did not seem to help. On Sunday morning, she had diarrhoea which the first room mate thought was a normal part of withdrawal.
51. The first room mate said that on Sunday afternoon she saw the woman open a chlordiazepoxide capsule and snort the powder. The capsules were part of the medication that she had been prescribed that afternoon. The first room mate was not sure what effect this would have, but she thought that it might cause drowsiness. She said that the woman was searched by officers. Once the officers had left the cell, the woman got another chlordiazepoxide capsule and snorted the contents. The first room mate said that the woman had concealed the tablets in her bottom. She said she had not seen her take any other substances and did not think that she had any other substances in her possession.
52. The first room mate said that in the evening she told staff that the woman was not well and was being sick. A nurse came to the hatch and looked through and told her to take her blanket off to cool her down. The nurse came back and gave her an injection.
53. The second room mate also said that she did not think the woman was an alcoholic but had been given advice in Reception to say that she was in order to get more medication. She said that on Sunday 9 December, the woman returned to room 28 after afternoon medication with four capsules of what she thought was chlordiazepoxide. She said she saw her break open one of the capsules and snort the contents from the top of a matchbox. All three of the

women who shared the room with the woman were present when this happened. The second room mate said that, shortly afterwards. The other officer on duty at the medication room hatch and the officer on duty came into the room and she and the other women were asked to leave. The other officer on duty at the medication room hatch also left the cell and another female officer went in to search the woman with the officer on duty.

54. After the search the second room mate saw the woman break open another capsule and snort the contents. The second room mate went out of the room and told the other officer on duty at the medication room hatch that the woman was "doing it again". She alleged that the officer responded "What can I do?" She said the officer on duty said, "I've already told her once". The second room mate said the officers told the nurses on duty but none of them came in to the room to see the woman as a result.
55. The second room mate described the woman's symptoms on 9 December as "more than a cluck". She said she vomited on to the floor and also into a cup. She said the woman was sick every couple of hours and every time she tried to drink something. She did not eat her teatime meal but lay on her bed wrapped up in her sheets. The second room mate heard her making a sort of choking noise. She said this was not like heavy breathing but a definite choking sound.
56. The second room mate said the prisoners in the room were worried about the woman and the third room mate (In room 28, who was released before my investigator could interview her) pressed the cell bell for the nurse. My investigator showed the second room mate the print out of the cell bell call system for 9 December. The second room mate identified the call timed at 6.43pm as the time when the third room mate pressed the bell. She said a nurse called [the other nurse] came to the hatch in the door and told the room mates that the woman's symptoms were withdrawal. The nurse told the room mates to unwrap the woman and said there was nothing that she could do. About 20 minutes later, she returned and gave the woman an injection.

THE POST MORTEM AND TOXICOLOGY REPORTS

57. The pathologist, who performed the woman's post mortem, found no obvious cause of death. The Coroner requested two toxicology reports, the first a test on samples of her blood, urine and injections sites, and the second, a test on a hair sample.
58. The woman's blood tested positive for metaclopramide at a concentration of 0.10mg/L (milligrams per litre). Her urine tested positive for benzodiazepine metabolites, metaclopramide, opiate metabolites and cocaine metabolites. Her injection sites tested negative for any compounds. Her hair sample showed use of dihydrocodeine, occasional use of amphetamines and ecstasy, habitual use of street heroin and heavy use of cocaine.
59. My investigator spoke to a member of staff from the toxicology laboratory that tested the woman's blood and urine. He said that the concentration of metaclopramide in the woman's urine was at the top end of therapeutic use. He said that, given the levels of opiate and cocaine metabolites in her urine and the fact that she had tested positive for opiates and cocaine on Saturday night, it was most likely that the opiates present were from drug use prior to entering prison. The benzodiazepine metabolites could be explained by her chlordiazepoxide treatment for alcohol withdrawal.
60. My investigator asked the member of staff from the toxicology laboratory why the woman's blood and urine had not tested positive for buprenorphine. He said that there was no blood assay test for buprenorphine. He checked the hard copy of the report and said that the urine test had shown "slightly positive" for buprenorphine. He said that this result was not recorded on the report because there was no confirmation test available. Results for buprenorphine were only recorded if a good history was available. My investigator told him that the woman had been prescribed buprenorphine but had vomited during her first dose. He agreed to send an amended report to the Coroner confirming and explaining the buprenorphine reading.
61. Following receipt of the toxicology reports, the pathologist issued his Post Mortem report. The cause of death was given as "unascertainable". In the remarks section he wrote:

"Death is consistent with Sudden Adult Death Syndrome with morphologically normal heart. The toxicology reports showed past and recent misuse of drugs and no evidence of fatal intoxication."

ISSUES CONSIDERED DURING THE INVESTIGATION

The clinical care offered to the woman at Holloway

62. The clinical review provides a comprehensive account of the woman's clinical treatment at Holloway. I draw the attention of the PCT and the Governor and Head of Healthcare at Holloway to the clinical reviewers findings and comments. I discuss the main points from the review below.
63. The PCT is the purchaser of healthcare at Holloway and Central and North West London Mental Health NHS Trust (CNWL) is the provider. There are three sets of guidelines which Holloway must comply with. PSO 3550 'Clinical Services for Substance Misusers' sets out the minimum requirements. In addition, Holloway has its own local protocol. This guidance is shared with HMP Pentonville and HMP Wormwood Scrubs. Holloway should also be compliant with the requirements of the Department of Health publication 'Clinical Management of Drug Dependence in the Adult Prison Setting' (referred to henceforth as the DH guidance), unless the prison is not funded to do so.

The decision by the reception doctor to prescribe the woman chlordiazepoxide

64. In her interview with the reception doctor, the woman appears to have said that she was normally a moderate drinker consuming about 32 units a week. In the week before she arrived at Holloway, however, she said she had drunk five cans of Special Brew a day (at least 20 units). Holloway's local substance misuse protocol advises that alcohol dependence is usually indicated if a person drinks more than 15 units of alcohol a day. Unless that person presents as intoxicated in reception, alcohol detoxification should begin that night using the moderate regime. The reception doctor said the woman had a tremor which he thought was the first sign of alcohol withdrawal.
65. The woman's family told my investigator that she was not a drinker. The first and second room mates in room 28, and the room mate in room 18, all said at interview that they did not think she was an alcoholic. They thought that she had been advised by another prisoner in Reception to exaggerate her alcohol consumption in order to obtain more medication. The majority of the women received into Holloway are neither new to prison nor to Holloway and will know that Holloway does not prescribe any medication for opiate withdrawal on the first night in custody. They will also know that alcohol detoxification begins in reception with a 'stat' dose (medication to be dispensed and taken immediately) of chlordiazepoxide. It is therefore highly likely that women may give false information about their alcohol intake in order to be given something to 'take the edge off' their first night of opiate withdrawal. This was the woman's first time in prison and she would not have been familiar with this practice. I have no direct evidence that she was advised to lie about her alcohol intake but it seems to be the most likely explanation.
66. With hindsight it seems that the woman did not require detoxification from alcohol. The reception doctor told the clinical reviewer at interview that he had received no particular training in substance misuse and detoxification. He was

not familiar with alcohol socially or professionally, and was not sure how many units of alcohol are contained in a can of strong lager. The woman presented with a history of a single week drinking at a level that would indicate alcohol dependency. The local guidance says, "Detoxification is indicated where there is a recent history of excessive alcohol consumption." It does not specify what 'recent' may mean, but I contend that her claim that she was normally a moderate drinker apart from the last week should cause some doubt about the truthfulness of what she said and the need for alcohol detoxification.

67. The reception doctor's role is to provide a triage assessment of the prisoner's immediate needs. If any form of substance misuse and detoxification is indicated, the prisoner is transferred to H1 and receives a further assessment from the H1 doctor the next morning. The H1 doctor will review the treatment prescribed in reception and will also have an opportunity to observe the woman once her withdrawal symptoms have fully begun. However, the H1 doctor only works Monday to Friday. Women who are received into Holloway during Friday evening and Saturday do not see the H1 doctor until Monday morning. They will only see another doctor during the weekend if concerns about their health are raised. There was no doctor on H1 on Sunday morning to review the reception doctor's diagnosis, question the woman further about her alcohol intake or observe her withdrawal symptoms.
68. At the weekend staff can contact an out of hours service provided by CAMIDOC (an independent not for profit company employed by the PCT). Throughout the investigation, it became clear that staff at Holloway have little confidence in the service provided by CAMIDOC and are disinclined to call them. The reception doctor's diagnosis is therefore crucial for women, like this woman, who arrive during Friday evening and Saturday.
69. I do not intend to be unduly critical of the reception doctor's decision to prescribe alcohol detoxification for the woman. He has not been provided with training and receives no supervision. Alcohol withdrawal can be life threatening and it is more dangerous not to prescribe anything. Faced with a person claiming to have drunk excessively in the week prior to custody he would be damned if he did and damned if he didn't. What concerns me is that there was no review of his decision the following day. Had she lived the woman would have received chlordiazepoxide (for a condition she almost certainly did not have) in combination with buprenorphine for 36 hours before being reviewed by the H1 doctor. As is noted in the clinical review, chlordiazepoxide is a benzodiazepine and caution is urged about prescribing benzodiazepines and buprenorphine together because the combination can be toxic.
70. A person is most vulnerable in the first 72 hours of withdrawal and detoxification. It is therefore essential that they are assessed and monitored by a properly trained and experienced doctor on first Reception and every day thereafter during detoxification. I consider that women arriving at Holloway on Friday evening and on Saturday face an unacceptable delay before they are assessed by a properly qualified doctor on H1. Given that the majority of women received into Holloway require some form of detoxification, I consider

that an appropriately trained doctor must be available in Reception and on H1 and D1 seven days a week.

71. I am also concerned that there are similarities between the woman's treatment and that afforded to another woman who died in Holloway in 2005. In that case a recommendation was made that:

“A diagnosis of drug or alcohol dependence should always be supported by a history of: past use; the length and pattern of this use; the amounts used with routes of administration; and frequency of use as a minimum.”

Holloway accepted this recommendation in November 2007 and responded, “First night and next day comprehensive assessments are taken by medical practitioners prior to commencing treatment.” This is not the case for women who arrive at the prison on Friday evenings and Saturdays.

I recommend that the PCT provide training in substance misuse for all doctors employed in Reception at Holloway.

I recommend that the PCT provide doctors in Reception at Holloway with dedicated supervision sessions.

I recommend that the PCT provide a properly trained doctor on H1 seven days a week.

Withdrawal monitoring Sunday 9 December

72. Withdrawal monitoring at Holloway is carried out after breakfast on the first three days of a woman's stay on H1. This is in accordance with PSO 3550. A HCA takes baseline observations (blood pressure, temperature and pulse) and records the readings by hand on a chart in the woman's IMR. Abnormal readings are written in red. The HCA also goes through a document called 'withdrawal monitoring chart' that lists a number of possible symptoms present during withdrawal. The HCA asks the woman to score her experience of them. The options are nil, one (mild), two (moderate), and three (severe). There is an additional document called 'withdrawal monitoring explanations' which provides advice on what to do if certain symptoms are present.
73. The withdrawal monitoring chart is relatively comprehensive but dates back to 1997 when Holloway's first detoxification unit opened. It was revised in 1999 but has not been updated since. Subsequent DH guidance recommends a validated opiate withdrawal scale such as Gossop 1990. The clinical reviewer points out in the clinical review, that Holloway's withdrawal monitoring chart does not include all of the signs and symptoms of opiate withdrawal cited by the DH.
74. Once the baseline observations have been taken and the chart completed, the woman takes them to the nurse at the hatch in the medication room. Any abnormal readings are recorded in red and reported to the nurse who in turn reports them to the H1 doctor (or CAMIDOC at weekends) who will assess the

woman and prescribe accordingly. Women on buprenorphine detoxification have their observations taken daily. Abnormal readings should prompt further observations to be taken in the afternoon.

75. On Sunday 9 December, the woman's withdrawal monitoring chart showed she was experiencing mild symptoms of the following: "nausea/vomiting, stomach cramps, fluctuation of mood, tremors/shakes, unsteady gait, diarrhoea, runny nose, sleep – too much – drowsy, agitation/restlessness and disturbed behaviour". Her blood pressure and pulse were normal but her temperature was 37.8C (high) and was recorded in red. The medication room nurse told my investigator that she remembered the woman had a high temperature and said she gave her some paracetamol. The nurse said that she wrote the woman's name on a piece of paper indicating that she should have further observations in the afternoon. She said this paper was not part of the woman's medical record but was simply a note for staff on duty telling them which women would need extra observations in the afternoon. She said that if afternoon observations are required they are done before the women receive their afternoon medication. The woman did not have a second set of observations before her afternoon medication. A doctor was not contacted.
76. The woman's urine test from the previous evening had indicated a urinary tract infection and she had been hit during the night. A high temperature may indicate a number of things including head injury, an infection and opiate toxicity. I am concerned that her high temperature did not prompt staff to explore possible underlying causes for it or ask a doctor to examine her.
77. The woman also reported mild diarrhoea to the HCA. She did not receive any medication for this. Holloway's local protocol (page 7) describes the treatment guidelines for using buprenorphine. The second bullet point says that in the presence of unsteady gait and drowsiness, buprenorphine should be withheld and urgent medical advice sought. The woman was given buprenorphine despite reporting mild drowsiness and unsteady gait.

The woman's vomiting

78. The woman reported mild nausea and vomiting to the HCA. She then vomited twice while taking her first dose of buprenorphine. She was given an injection of metaclopramide by the dispensing nurse. The nurse said it was "fairly normal" for women to vomit during detoxification. She did not think the woman seemed any more unwell than any other woman experiencing withdrawal. The women in room 28 reported that she was sick frequently throughout Sunday 9 December. One of them said she was sick "every two hours". They reported that she was sick when she tried to drink, and did not eat her teatime meal. The other officer on duty at the medication hatch recalled the woman being sick during the afternoon. On this occasion she brought up bile. The women in room 28 told officers that the woman was still being sick at 6.30pm. The other nurse gave her another injection of metaclopramide at about 7.00pm. She was not reported to have vomited again.

79. A doctor's authorisation is normally sought for intra-muscular injections of metaclopramide. As there was no doctor on H1 on Sunday, no authorisation was sought. The woman had a number of doses of metaclopramide in a short space of time but, according to both the clinical review and the member of staff from the toxicology laboratory, this would not have had an adverse physical effect. Nevertheless, metaclopramide is a drug associated with special warnings, especially when treating young women under 20 years old. I am concerned that, in the absence of the H1 doctor, nurses are giving injections without authorisation.
80. Persistent vomiting can be a life threatening condition in women already debilitated by drug use. It can also be an indication both of head injury and urinary tract infection. No consideration appears to have been given to the fact that the woman might have been more seriously injured during the incident in the night than first thought. The fact that her urine test indicated a urinary tract infection appears to have been completely ignored. She had reported diarrhoea – and in combination with persistent vomiting she may have been dehydrated. This too is a serious condition. She had a high temperature. Vomiting may indicate withdrawal or intolerance to prescribed medication and it should be monitored closely. Holloway's withdrawal monitoring explanation document raises these concerns. It says, "If the vomiting is excessive and does not respond to the giving of an anti-emetic the unit doctor should be asked to reassess the patient, and transfer to outside hospital must be considered."
81. I have seen no evidence that any of these symptoms raised concern among staff. I consider that the woman's symptoms warranted referral to a doctor as per the advice contained in the withdrawal monitoring explanation document and as per what I am told is usual practice on H1 during the week. I am concerned that staff on H1 simply accept vomiting as a part of withdrawal and do not look for underlying causes. I discuss below the staffing levels at Holloway and the impact this may have on the ability of staff to devote time to individuals and to think imaginatively about their needs and treatment. In my report into the death of a woman at Holloway in 2005, a recommendation was made that vomiting and diarrhoea during withdrawal should be closely monitored. This recommendation was accepted by the prison in November 2007 with the response, "in place, however this is almost non-existent due to more comprehensive care". I have seen no evidence that she was monitored more closely as a result of her persistent vomiting. A significant number of the staff interviewed during this investigation commented that vomiting and fitting during withdrawal was common on H1. Were vomiting to be almost non-existent as the prison response suggests, there would have been even more reason to monitor the woman closely.
82. I note also that, despite her persistent vomiting, the woman was given 400mg of Ibuprofen three times on Sunday. Ibuprofen is known to cause gastric irritation.

The 'snorting' incident on the afternoon of Sunday 9 December

83. Following information from another prisoner that the woman had not swallowed her afternoon dose of chlordiazepoxide, she was searched by staff and a nurse was informed. The officers completed the required entries in the wing observation book and her wing history sheets. They also completed a chain of custody form for the empty capsule and the powder that they found in her possession. The night staff were made aware of the incident when they came on duty. Two nurses took the woman's baseline observations and recorded them on the appropriate chart in her IMR. She had a temperature of 38C and this was written in red to indicate it was an abnormally high reading. The nurses did not complete any further withdrawal monitoring. At interview, the other nurse explained that this would have meant filling in the 'Day 2' column and it was not day two. After the search the women in room 28 told two officers that she had 'snorted' the contents of another chlordiazepoxide capsule. She was not searched again. The other officer on duty at the medication hatch said he did not consider moving her and did not inform nursing staff. The officer on duty could not remember being told about this incident but said she was unsure if another search was allowed so soon after the first one. The second room mate said the officers had told the nurses what had happened but no nurse came to see her.
84. I consider that the nurses should have completed the withdrawal monitoring form after this incident – especially as the woman's temperature had risen since her baseline observations were taken that morning and in the light of her persistent vomiting. I also consider that a doctor should have been called and asked to reassess her. During the course of the investigation, my investigator asked every member of staff and prisoner she spoke to if they had ever come across a person 'snorting' the contents of a chlordiazepoxide capsule. (Together the staff and prisoners represent a huge amount of experience both in the treatment of substance misuse and in misusing substances.) Every single person said they had never come across it and did not know what effect it might have. In view of the fact that no one knew what might happen to someone who had 'snorted' chlordiazepoxide, I consider that it was even more necessary to increase the monitoring of the woman's withdrawal symptoms and to inform a doctor. Staff were aware that she had ingested more chlordiazepoxide after the search – this should also have prompted increased monitoring and referral to the doctor. There is no record of this incident on EMIS.
85. I also consider that the woman should have been searched again. If staff were unsure whether they had a right to do this, they should have asked a senior officer or governor grade. The illicit use of prescribed medication on a detoxification unit is a serious issue and every attempt should have been made to recover the substances and separate her from other women. I am aware that H1 was full on Sunday 9 December, but the possibility of moving her was not given any consideration. The SO was on duty but was not informed of the incident.

I recommend the Governor of Holloway considers whether it is necessary to provide extra guidance for staff on the appropriate action to take if a prisoner is found in possession of illicit substances on H1.

EMIS and record keeping

86. EMIS is an electronic record keeping system designed for use in GP's surgeries. In the community a doctor has 1:1 patient consultations in a surgery and can make the entries on EMIS during the consultation. EMIS is not designed for use in a busy substance misuse unit like H1. It is more suited to doctors entering information during assessment (such as the one the reception doctor did in reception) than to nurses recording conversations and incidents that happen as they walk around H1. During the course of the investigation it became apparent that EMIS was not conducive to regular, clear, contemporaneous or detailed record keeping. All of the nurses interviewed said that EMIS discouraged them from making more comprehensive and descriptive entries. The entries in the woman's record bear this out. There is little information about the nature and frequency of her vomiting. There is no reference to the medication room nurses' conversation with her at 1.00pm and the oral dose of metaclopramide she may have given her. The medication room nurse went off duty at about 1.00pm. There is no record at all of the 'snorting' incident and the other nurse's visit to the woman to take her baseline observations. There is no record that she asked the other nurse for a further injection of metaclopramide at about 9.00pm – possibly indicating she was still being sick.
87. Entries may be made several hours after the incidents occurred. H1 is a busy unit and staff usually keep a note in their own diaries or notebooks and update EMIS when they can find a minute to do so. This can make for a confusing picture if a member of staff who dealt with a subsequent incident updates EMIS before a member of staff who dealt with an earlier incident. For example, the woman was seen by the reception nurse first and then by the reception doctor but (in the consultations section) the reception doctor's entry appears before that of the reception nurse. If the medication room nurse did give the woman an oral dose of metaclopramide at 1.00pm, she would not have seen from EMIS that the dispensing nurse had given her an intra-muscular injection at 10.45am (although this was also written on the administration chart) because the dispensing nurse did not update EMIS until 2.50pm. Also entries are made using other users' log in information. I understand that this is because of the relatively high number of agency and locum staff covering shifts on H1 who do not have their own log in information, but it makes for a confusing audit trail. The H1 nurse did not, as EMIS suggests, enter the results of the woman's urine test. Had she done so, she might have noticed that she had a urinary tract infection.
88. In the active problems section on EMIS there is no reference to the incident in room 18 in which the woman suffered an injury. It is not clear what 'active problems' are and how they relate to the consultation section. The reception doctor listed alcohol dependency as an active problem but not opiate dependency. The dispensing nurse listed vomiting as an active problem on 9 December but there was no other entry about vomiting. There is no record that the urine test showed the woman had a urinary tract infection. It is not clear whether she was vaccinated against hepatitis or said she wanted to be. I consider that an abnormal baseline reading should also be entered in the

consultation section so a clear chronology of a patient's presentation can be built up.

89. In contrast to the EMIS record, the wing observation book appears to be well used by both discipline and clinical staff. Entries are detailed and respectful and it is clearly a useful tool in communicating incidents between shifts. I understand that the prison has approached the PCT for help in making EMIS more appropriate to their needs. This was recommended in my report of the investigation into the death of a woman at Holloway in 2005 and is an on-going part of the clinical governance plan. It is important that EMIS is reconfigured as soon as possible. In the meantime, consideration should be given to using the paper version of the continuous clinical record (contained in the clinical notes section of the IMR).

I recommend that the PCT give urgent consideration to making EMIS a more suitable tool for use on H1.

Staffing levels on H1

90. The clinical review concludes that the staffing levels at night are inadequate to ensure the safety, monitoring and supervision of some 60 women. They are significantly lower than staffing levels in equivalent substance misuse units in the community. The night staff impressed at interview with their dedication and attitude. However, H1 is a busy and demanding unit. The night staff are responsible for the evening round of medication which is dispensed through the door hatches. The amount of medication dispensed at night has been reduced to try to cut down on diversion (improper use), but this remains a problem. The clinical reviewer says in the clinical review:

“For a large ward of women with complex mental and physical health needs, in addition to detoxification support and monitoring, one qualified nurse and one HCA is unacceptable to ensure patient safety, monitoring and supervision. Compared to hospital or detoxification facilities this is seriously understaffed. Staffing levels need urgent review.”

91. I am also concerned about clinical staffing levels during the day. A common criticism of prison culture is that protocols are followed rather than people being treated as individuals. A significant impediment to this and to 'thinking outside the box' is the simple lack of time to do so. During the course of the investigation it became apparent that the nurses on H1 have little time to nurse. The staffing levels are adequate to cover the essential tasks such as dispensing medication, doing dressings and contacting services in the community to verify previous treatment but no more. I am told that a significant number of women enter the unit with appalling physical problems, such as abscesses, that need significant care and attention. Others have mental health issues that must be addressed. At the weekends the nurses have no support from a unit doctor. There is no confidence in using the out of hours service. The Clinical Services Manager told my investigator that a comparable substance misuse unit in the community has the same number of nursing staff

as H1 but deals with 19 patients compared to 60. Such a unit has strict entrance criteria – H1 takes all comers.

92. It is not ideal that a HCA completes the withdrawal monitoring scale. Ideally this should be done by a nurse qualified in substance misuse who can question the women in more detail about their symptoms. At present the HCA is responsible for conducting a 'tick box' exercise. They report any abnormal baseline readings or concerns about withdrawal symptoms to a nurse who is busy dispensing medication. In the absence of a doctor on H1 at weekends I am concerned that there is no proper assessment of how the women are progressing through withdrawal and detoxification. In my report into the death of a woman at Holloway in 2005 I recommended that Holloway return to using a self-assessment questionnaire for women on H1. This recommendation was not accepted as the prison believed it would lead to duplication of the assessment process. I remain unconvinced that this is the case and consider that it would be a useful aid to staff, especially on weekends.

I recommend that the PCT in conjunction with the Head of Healthcare at Holloway review the staffing levels on H1 with a view to increasing them.

I recommend that Holloway re-introduce the self assessment questionnaire.

Review of withdrawal monitoring on H1

93. In view of the issues discussed above and the concerns raised by this investigation, I consider that it is sensible for a review of practices on H1 to be undertaken by the PCT in conjunction with Offender Health.

I recommend that the PCT in conjunction with Offender Health conduct a detailed review of detoxification procedures and withdrawal monitoring on H1 at the earliest opportunity.

The prison's response to the incident in room 18 at 3.00am on the night of 8/9 December

94. The HCA quite properly attempted to defuse the argument in room 18 by speaking to the women through the door hatch. When it became apparent that this was not possible she informed her nursing colleague. The nursing colleague acted quickly and called discipline staff. Two officers happened to be on the same landing and arrived speedily. The staff assessed the situation and took the decision to move the woman to another room. While this transfer was arranged she was taken to the office and given a hot drink. The HCA discovered that the woman had been hit by two other prisoners and had sustained what appeared to be minor injuries. She was moved to room 28. One of the officers documented the incident in the wing observation book and on the woman's wing file, and a form F213 Report of Injury to Inmate (female) was completed. The next day the SO interviewed all three women and reviewed their cell sharing risk assessment forms.

95. I consider that this incident was well and sensitively managed. H1 was full and some thought was given to who it was most appropriate to move into room 18. Thought was also given to the fact that room 28 was near to the office and would give staff a better opportunity to make sure the woman was okay afterwards. The incident was well documented and the staff coming on duty the following morning were told about it at the hand-over. I am particularly pleased to see that the SO interviewed the woman the next day and reviewed their cell sharing risk assessments. This is a requirement after a fight but I have rarely seen an example of it being done so thoroughly.

The handling of the incident in room 18 by all staff involved is good practice.

The prison's response to the woman's death

96. I am satisfied that staff responded appropriately to the discovery that the woman was unresponsive on 10 December. The attending nurses and the women in room 28 all thought that she was already dead. Despite this the nurses attempted CPR until the arrival of paramedics. I note that the verification of the fact of death form completed by the ambulance paramedic at the scene commented that there was a delay in arriving on H1 because the gate was not opened when the ambulance arrived at the prison. I made a recommendation in my report into the death of a woman at Holloway in 2005 that the Governor review Holloway's arrangements for escorting emergency ambulances. In that case a delay occurred while waiting for a member of staff to escort the ambulance crew to the wing. In the woman's case any delay at the gate was not critical, but in the light of the comments made by the paramedic I make a similar recommendation.

I recommend that the Governor of Holloway review local arrangements for admitting emergency ambulances to the prison to ensure that paramedics arrive at the appropriate location with the minimum of delay.

97. I consider that the prison made good efforts to answer the family's questions in the aftermath of the woman's death. The Governor made her phone number immediately available to the woman's parents, and her father was able to speak to her the same night – this is good practice. The family were offered the opportunity to visit the prison, and time and staff were made available for them. However, the sad news of her death was actually broken to her family by the police. PSO 2710, Follow up to deaths in custody, recommends that the news is broken in person by prison staff. To support this the Prison Service has trained family liaison officers in each prison. I believe that the responsibility of breaking the news of a death in prison is properly the responsibility of prison staff.

The Governor's action in making her phone number immediately available to the woman's family was good practice.

98. As a matter of housekeeping, this is the second death at Holloway in the last 12 months and on both occasions staff incident reports were given to the police

before being copied and put in the evidence bundle for my investigator. It would help, in the unfortunate event of any further deaths, if these could be copied first. In all other respects the relevant documents were gathered speedily and made available to my investigator in good time. The standard of liaison offered to my investigator was exemplary.

99. The room mates, who shared room 28 with the woman on Sunday 9 December told my investigator that they were unhappy that they had been kept apart from the other women on H1 until they were interviewed by the police some five days later. This five day delay is regrettable. The prison was acting on the instructions of the police and was therefore obliged to comply. However, I am concerned at the potentially isolating and unsettling effect this would have had on women who had witnessed a traumatic event at the same time as going through their own withdrawal. Particular care should be taken to make sure staff speak regularly to women in such circumstances and that they are offered appropriate support. It is unlikely that these particular circumstances will be repeated but I draw this to the attention of the Governor for learning purposes.

CONCLUSION

100. The sad death of the woman remains unexplained by the post mortem and toxicology reports. Although I have highlighted a number of concerns about the detoxification procedures on H1 as applied in the woman's case, I must emphasise that no link between her death and the treatment she received at Holloway has been established.

RECOMMENDATIONS

1. I recommend that the PCT provide training in substance misuse for all doctors employed in Reception at Holloway.

This recommendation was accepted at draft stage and Holloway responded: The Consultant Specialist in Substance Misuse will provide training to all doctors that cover reception at HMP Holloway.

2. I recommend that the PCT provide doctors in Reception at Holloway with dedicated supervision sessions.

This recommendation was accepted at draft stage: The PCT salaried doctors contracted to practice at Holloway are appraised on an annual basis in line with BMA procedures. The lead GP at Holloway will ensure that clinical support, supervision and training are provided to relevant doctors.

3. I recommend that the PCT provide a properly trained doctor on H1 seven days a week.

See response to 6 below

4. I recommend the Governor of Holloway considers whether it is necessary to provide extra guidance for staff on the appropriate action to take if a prisoner is found in possession of illicit substances on H1.

This recommendation was accepted at draft stage: The Governor of HMP Holloway will review the searching policy to ensure that discipline officers adhere to correct procedures when illicit substances are found on a prisoner.

5. I recommend that the PCT give urgent consideration to making EMIS a more suitable tool for use on H1.

This recommendation was accepted at draft stage: The Head of Healthcare and SMS provider will assist the PCT to amend EMIS accordingly.

6. I recommend that the PCT in conjunction with the Head of Healthcare at Holloway review the staffing levels on H1 with a view to increasing them.

This recommendation was accepted at draft stage: The staff profile and skill mix will be reviewed by the Head of Healthcare and recommendations submitted to the Prison and PCT Prison Health Partnership Board.

7. I recommend that Holloway re-introduce the self assessment questionnaire.

8. I recommend that Islington PCT in conjunction with Offender Health conduct a detailed review of detoxification procedures and withdrawal monitoring on H1.

This recommendation was accepted at draft stage:

The PCT and Governor of Holloway will commission an expert review into all detoxification procedures and withdrawal monitoring.

9. I recommend that the Governor of Holloway review local arrangements for admitting emergency ambulances to the prison to ensure that paramedics arrive at the appropriate location with the minimum of delay.

This recommendation was accepted at draft stage:

The Governor of HMP Holloway will review the establishment procedures to ensure timely admittance of emergency services into the prison.

Good practice:

The handling of the incident in room 18 by all staff involved was good practice.

The Governor's action in making her phone number immediately available to the woman's family was good practice.