

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Yvonne McCluskie a prisoner at HMP Eastwood Park on 28 January 2018

A report by the Prisons and Probation Ombudsman

Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*

Respectful: *we are considerate and courteous*

Inclusive: *we value diversity*

Dedicated: *we are determined and focused*

Fair: *we are honest and act with integrity*



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The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Ms Yvonne McCluskie died in her cell at HMP Eastwood Park in the early hours of 28 January 2018, six days after arriving at the prison. The post-mortem found that she died from the effects of long-term alcohol misuse. Ms McCluskie was 43 years old. I offer my condolences to Ms McCluskie's family and friends.

Ms McCluskie had a long history of drug and alcohol misuse. When she arrived at Eastwood Park she was placed on an appropriate detoxification programme, prescribed appropriate medication and monitored appropriately. Although intelligence reports suggested that she might have been trying to obtain prescribed medication illicitly from other prisoners, toxicology tests did not reveal the presence of any drugs in her system beyond those she had been prescribed. The fact that she was not given her prescribed medication the night before she died does not seem to have played a part in her death.

I am satisfied that staff at Eastwood Park could not have foreseen or prevented Ms McCluskie's death and I make no recommendations.

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

Sue McAllister, CB
Prisons and Probation Ombudsman

February 2019

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Summary

Events

1. On 22 January 2018, Ms Yvonne McCluskie was convicted of various offences and admitted to HMP Eastwood Park. She had a history of drug and alcohol misuse, and suffered from depression and anxiety. She had been in prison before. On arrival she tested positive for opiates and cocaine and said that she drank heavily in the community. She was put on a detoxification programme and prescribed related medication.
2. Medical staff kept Ms McCluskie under observation, including during the night, to ensure that her detoxification was managed appropriately. Ms McCluskie was calm and polite during her time in Eastwood Park, though she did decline to have medical observations taken, saying that she felt well.
3. On Saturday 27 January, a member of the healthcare team went to Ms McCluskie's cell to take some medical observations, which she declined. Later that evening, a nurse went to her cell to administer her prescribed medication, but Ms McCluskie was asleep. The nurse made a visual check, assessed the need for the medication and, having no reason to be concerned, decided not to wake Ms McCluskie.
4. At 7.22am the next morning, a prison officer was making a roll check and saw Ms McCluskie lying on the floor. He called for colleagues, they went into the cell, and were unable to rouse her. They raised an emergency alarm, and medical staff joined them and attempted to revive Ms McCluskie. They continued in their attempts until ambulance staff arrived and took over. At 7.52am it was agreed that Ms McCluskie had died.
5. The post-mortem report recorded her cause of death as 'sudden unexpected death associated with chronic alcohol misuse'.

Findings

Ms McCluskie's healthcare

Detoxification

6. The clinical reviewer found that Ms McCluskie's withdrawal was appropriately managed and she was prescribed appropriate medication. Staff kept her under observation, and she did not suffer significant physical symptoms of withdrawal. The pathologist who conducted her post-mortem examination did not think that the medication she had taken caused Ms McCluskie's death.
7. Although there was some intelligence to suggest that Ms McCluskie might have been seeking to obtain further medication from other prisoners, no medication was found in her cell after her death and toxicology tests found only therapeutic levels of medication that she had been prescribed in her system.

Missed medication on 27 January

8. On the night of 27 January, Ms McCluskie was asleep when a nurse brought her medication, so she did not receive it. The clinical reviewer noted that this was not likely to have contributed to Ms McCluskie's death.

Emergency response

9. When a prison officer found Ms McCluskie unresponsive he called for assistance and staff went into the cell with minimal delay. They called an emergency code, which prompted the control room to summon an ambulance. Healthcare staff arrived quickly and made appropriate attempts to resuscitate her until ambulance staff arrived.

Overall care

10. We agree with the clinical reviewer that the care provided to Ms McCluskie was equivalent to the care she could have expected in the community. The cause of death was given as 'sudden unexpected death associated with chronic alcohol misuse', and we do not consider that staff at Eastwood Park could have anticipated or prevented Ms McCluskie's death.
11. We make no recommendations.

The Investigation Process

12. The investigator issued notices to staff and prisoners at HMP Eastwood Park informing them of the investigation and asking anyone with relevant information to contact him. There were no responses.
13. The investigator obtained copies of relevant extracts from Ms McCluskie's prison and medical records. Eastwood Park was unable to provide cell call bell records as these were not recorded.
14. NHS England commissioned a clinical reviewer to review Ms McCluskie's clinical care at the prison.
15. We informed HM Coroner for Avon of the investigation. She gave us the results of the post-mortem examination and we have sent the Coroner a copy of this report.
16. One of the Ombudsman's family liaison officers contacted Ms McCluskie's sister, to explain the investigation and to ask whether she had any matters the family wanted the investigation to consider. Ms McCluskie's sister asked about her medication, and whether she had been checked during the night,
17. Ms McCluskie's sister received a copy of the initial report. She did not raise any further issues, or comment on the factual accuracy of the report.

Background Information

HMP Eastwood Park

18. Eastwood Park is a closed prison in Gloucestershire, which can hold up to 442 women. It has 10 residential wings, two of which specialise in dealing with prisoners with substance misuse issues. The Kinnon Unit holds new prisoners who need detoxification treatment. Healthcare is provided by Inspire Better Health.

HM Inspectorate of Prisons

19. The most recent inspection of HMP Eastwood Park was conducted in November 2016. Inspectors reported that care and support for prisoners was strong. The substance misuse strategy was well managed.

Independent Monitoring Board

20. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to October 2017, the IMB reported that it was impressed with the professional and caring approach of managers and staff at the prison. Levels of violence and self-harm were high but management showed a consistently detailed knowledge of, and concern for, individuals involved.

Previous deaths at HMP Eastwood Park

21. Ms McCluskie was the twelfth prisoner to die at Eastwood Park since 2013. A number of these deaths occurred on the Kinnon Unit and there has since been a further death. None of the previous deaths have similarities to that of Ms McCluskie.

Key Events

22. On 22 January 2018, Ms McCluskie was convicted of various offences including burglary, theft and possession of a controlled drug, and sentenced to 26 weeks imprisonment. She was taken to HMP Eastwood Park.
23. Ms McCluskie had a history of drug and alcohol misuse. She had a number of previous offences and had been in prison before, most recently in 2016. Police and escort papers that accompanied her to prison noted that she suffered from depression and anxiety. She said that she had been prescribed mirtazapine (an antidepressant), and she had some in her possession on arrival.
24. In a reception health screening Ms McCluskie tested positive for opiates, cocaine, and benzodiazepine (a sedative used to treat anxiety). She said that she drank three litres of strong cider each day, and had suffered a seizure since being taken into custody. Ms McCluskie was referred for detoxification. Dr A prescribed methadone (an opiate substitute to aid detoxification), chlordiazepoxide (to reduce the serious side effects of withdrawal from alcohol, including the risk of further seizures) and mirtazapine.
25. No concerns were identified during the reception and induction processes. Ms McCluskie was calm and polite, and said that she had no issues she wanted to raise. She declined the offer of a telephone call. She was allocated a cell on K2, the detoxification unit. It was a double cell but Ms McCluskie was the only occupant. Medical staff visually checked on her during the night, in line with Eastwood Park's substance misuse policy.
26. The following morning, Ms McCluskie declined to have her basic medical observations taken. In a basic custody screening interview, she said that she had not had contact with mental health services. A member of the chaplaincy made an introductory visit, and Ms McCluskie asked if they could arrange a telephone call to her family but this was not possible at the time. She did not raise any other issues. The healthcare department had requested her medical history from her GP, which arrived that afternoon. A healthcare assistant saw her, and indicated on her medical record that she was suffering from mild withdrawal symptoms. She was also visited by a member of the resettlement team to discuss accommodation after her release. Medical staff again conducted visual checks on Ms McCluskie during the night.
27. On 24 January Ms McCluskie completed her induction programme and was given her prison identification card to allow her to use the prison's facilities. Officer A explained prison rules and regimes, and Ms McCluskie signed the relevant compacts. The officer noted that Ms McCluskie was polite throughout the process and engaged well. Medical staff visually checked her during the night.
28. On 25 January, healthcare staff tested Ms McCluskie's blood, kidney and liver functions. All the results were normal. The following day she saw Dr B, a GP, and complained of insomnia. The doctor prescribed her some sleeping pills. During the appointment, Ms McCluskie told the doctor that she had been sexually assaulted in the past, and had reported this to the police.

29. On Friday 26 January, Nurse A gave Ms McCluskie her prescribed dose of acamprosate, a medication used to treat alcohol dependence. Intelligence reports indicated that the same day Ms McCluskie was pressuring other prisoners to conceal their medication rather than take it when it was dispensed to them. Staff were advised to be extra vigilant around the medication distribution area.
30. On Saturday 27 January, prisoners were locked into their cells at approximately 5.45pm. At 7.22pm a healthcare assistant, went to take Ms McCluskie's basic medical observations but she declined to have them taken.
31. At 10.40pm Nurse A went to Ms McCluskie's cell to dispense her scheduled medication: zopiclone and chlordiazepoxide. Ms McCluskie was in a deep sleep and was snoring loudly. Prescriptions distributed at night are passed to prisoners through the hatch in their cell doors; cells are only unlocked in an emergency. The nurse called to Ms McCluskie through the hatch but she remained asleep. The nurse used her torch to check Ms McCluskie and could see that she was breathing normally. She could not detect any unusual odours or sounds, and there were no bodily fluids or drug paraphernalia visible around her. Having considered the medication that was due, the nurse had no concerns about Ms McCluskie and took the decision not to wake her.
32. There is no evidence to show that Ms McCluskie came to staff's attention during the night.
33. At 7.22am on 28 January, Officer B was conducting the morning roll check. When he reached Ms McCluskie's cell, he looked through the observation panel and saw Ms McCluskie lying on the floor. He called to Officer C and an OSG to join him and they went into the cell. They were unable to get any response from Ms McCluskie.
34. One of the officers used his radio to call a code blue emergency. (This means a prisoner is unconscious, having difficulty breathing or not breathing.) The emergency call was made at 7.24am. This automatically triggered the control room to request an ambulance.
35. Staff responded to the emergency call. Nurse A and Nurse B arrived at Ms McCluskie's cell at approximately 7.25am and began trying to revive her. Joined by further medical staff, they continued to do so until ambulance paramedics arrived and took over. At 7.52am they pronounced Ms McCluskie dead.

Contact with Ms McCluskie's family

36. Ms McCluskie had listed her sister as next of kin. Two family liaison officers travelled to her home to break the news of Ms McCluskie's death. In line with guidance, they offered a contribution to the cost of the funeral.

Support for prisoners and staff

37. After Ms McCluskie's death, one of the prison's managers, debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

38. The prison posted notices informing other prisoners of Ms McCluskie's death, offering support if required. All prisoners subject to special monitoring for the risk of self-harm had their situations reviewed in case they had been adversely affected by Ms McCluskie's death.

Information received after Ms McCluskie's death

39. Some prisoners subsequently told staff that rather than taking it, Ms McCluskie had stockpiled her medication. There was also intelligence to suggest that Ms McCluskie may have been buying illicit drugs from another prisoner. When staff cleared Ms McCluskie's cell there was no evidence of stockpiled medication.

Post-mortem report

40. The post-mortem found no signs to suggest that Ms McCluskie had been restrained or assaulted prior to her death and no external or internal injury to account for her sudden death. Toxicology tests found the presence of methadone and chlordiazepoxide compatible with the levels of medication Ms McCluskie had been prescribed. The pathologist considered that the possibility that Ms McCluskie's death was due to the drugs she was taking could not be entirely ruled out, but concluded, on the balance of probabilities that Ms McCluskie's cause of death was 'sudden unexpected death associated with chronic alcohol misuse'.

Findings

Ms McCluskie's healthcare

Detoxification

41. The clinical reviewer noted that the healthcare team treated Ms McCluskie appropriately in managing her alcohol and opiate withdrawal. She was involved in her own care, staff kept her under observation, and saw her regularly, making appropriate observations. She did not suffer significant physical symptoms of withdrawal. In line with Eastwood Park's policy for newly-arrived prisoners who are detoxifying from drug and/or alcohol misuse, medical staff checked on her during her first three nights in prison.

Missed medication on 27 January

42. On the night of 27 January, Nurse A found Ms McCluskie asleep when she went to administer her medication. Unable to rouse her, she satisfied herself that Ms McCluskie was breathing with no apparent problems. She considered the intended effects of the medication she was due to administer, assessed whether she ought to make further attempts to wake her, and decided against doing so because she was worried about the sedative effects of the medication on someone who was already sleeping heavily.
43. The clinical reviewer considered that the chlordiazepoxide should have been administered. However, he considered that the fact that it was not given was unlikely to have contributed to Ms McCluskie's death because she had displayed no obvious sign of excitability or anxiety that might have been attributed to alcohol withdrawal.
44. There is nothing to suggest that Ms McCluskie sought any assistance during the night, although the prison was unable to provide cell bell records due to a technical issue.

Overall care

45. While intelligence gathered after Ms McCluskie's death suggested that she had been attempting to acquire extra medication from other prisoners, the toxicology report indicated that the levels of methadone, chlordiazepoxide and mirtazapine in Ms McCluskie's system were in line with the quantities she had been prescribed. There was no evidence found in her cell of any excess medication. The pathologist who conducted her post-mortem examination did not think that there was evidence that the medication she had taken had caused Ms McCluskie's death.
46. The clinical reviewer concluded that the care provided to Ms McCluskie in Eastwood Park was equivalent to the care she could have expected in the community. He did not make any recommendations.

Emergency response

47. When Officer B found Ms McCluskie unresponsive he called for assistance and staff went into the cell with minimal delay. When the officers found Ms

McCluskie unresponsive, they used the correct emergency code, which prompted the control room to summon an ambulance. They tried to rouse Ms McCluskie but were unable to do so. Healthcare staff arrived quickly and attempted to resuscitate her until paramedics arrived and took over.

48. The clinical reviewer noted that, while it likely that Ms McCluskie had already been dead for some time when she was found on the morning of 28 January, the resuscitation attempts were appropriate.

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