IN THE SURREY CORONER'S COURT
IN THE MATTER OF:

The Inquest Touching the Death of
Natasha Learline CHIN
A Regulation 28 Report – Action to Prevent Future Deaths

	THIS REPORT IS BEING SENT TO: • **Denis Machuel, Chief Executive, Sodexo Justice Services.** • **Ian Trenholm Chief Executive Care Quality Commission** • **Elizabeth Moody, Police and Prisons Ombudsman** • **Peter Clarke, Her Majesty's Chief Inspector of Prisons.** • **Right Honourable David Gauke MP, Minister for Justice**
1	**CORONER** Caroline Topping HM Assistant Coroner, for the County of Surrey
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** An inquest into the death of Miss Natasha Chin was opened on 29th July 2016 and resumed with a jury on 5th November 2018. The jury returned their conclusion on the 28th November 2018 having been in retirement for 4 hours and 26 minutes. They concluded that Miss Chin died on the 19th July 2016 at HMP Bronzefield and that the medical cause of her death was ; 1a. Cardiac arrest due to ventricular arrhythmias 1b Hypomagnesemia , hypokalemia and myocardial scarring 1c Chronic cocaine use. ll Chronic alcohol abuse and/or dependence

They concluded with a narrative conclusion and found that:
On the 19th July 2016 Natasha Learline Chin died at HMP Bronzefield, Woodthorpe Road, Ashford Middlesex, TW15 3JZ.
Miss Chin was recalled to prison following a breach of licence. She had a history of serious drug and alcohol abuse.
Between the hours of 9.14 and 18.36 on the 19th July 2016:

a.) The healthcare staff failed:

i.) to ensure that Miss Chin had her prescribed medication when due.

ii.) to escalate Miss Chin's failure to have her medication in accordance with policies.

iii.) to undertake the opiate and alcohol withdrawal scales.

iv.) to carry out any adequate assessments or observations and record them. Such assessments and observations would have enabled Miss Chin to receive and have adjusted her medication.

v.) to monitor her vomiting adequately or at all.

vi.) to respond to the prison officer's request for help timeously.

vii.) to put in place any adequate handover at lunchtime.

viii.) to monitor the level of Miss Chin's hydration.

b.) The operational staff failed:

i.) to follow the escalation protocol for welfare concerns.

ii.) to diligently record welfare concerns according to policy.

They concluded that:
Miss Chin's death was caused or more than minimally contributed to by a systemic failure through poor governance which led to a lack of basic care.
The death was contributed to by neglect.
The death was caused or more than minimally contributed to by the failure on the part of Sodexo Justice Services to

i.) ensure the prompt administration of prescribed medication

ii.) ensure that medical records were checked before clinical observations were undertaken or medication administered.

4	**CIRCUMSTANCES OF THE DEATH** The Jury heard evidence that Miss Chin had been recalled on licence and admitted to HMP Bronzefield on the afternoon of the 18th July 2016. The prison is run by Sodexo Justice Services. Miss Chin was seen by a doctor on admission and prescribed medication to treat the effects of alcohol and opiate withdrawal. The prescribed medications were administered on the 18th July 2016. On the 19th July 2016 methadone was prescribed to be administered at 8.00 am and chlordiazepoxide was prescribed to be administered at 8.00 am and 12 noon. Neither medication was administered to Miss Chin until 18.34 that evening. She vomited profusely as a consequence of undertreated opiate and alcohol withdrawal during the course of the 19th July 2016. The prison officer responsible for the wing that Miss Chin was resident on was not aware of what Miss Chin had been prescribed nor when medication was due to be administered. She raised concerns about Miss Chin's condition to a nurse in the late morning and again at about 16.00. Miss Chin was not seen by a member of the clinical staff until 18.07. The prison officer did not escalate her concerns about Miss Chin's condition to a more senior officer when the clinical staff did not respond timeously. No clinical observations were undertaken of Miss Chin's condition between 9.14 and 18.34 and no records were kept of her fluid loss or intake on the 19th July 2016. Observations which were undertaken at 9.14 and 18.34 on the 19th July 2016 were not in accordance with National or Sodexo Justice Service's protocols for those withdrawing from opiates and alcohol. The protocol which required both notification to a doctor to be made, and a datix report to be created, in the event of a failure to administer prescribed medication at the correct time was not adhered to in either respect. An anti- emetic, metochlopramide, was administered after 18.07 to Miss Chin by a nurse. It was administered in contravention of the Patient Guidance Direction. The nurse administered it without reference to Miss Chin's System 1 medical records. Miss Chin's previous medical history precluded a nurse from administering metoclopramide. The medication should have been prescribed by a doctor. No record was made of the observations said to have been undertaken at 6.34 on the 19th July 2016. No record was made of the

	administration of metochloramide on the evening of the 19th July 2016. Miss Chin died sometime before 10.41 on the 19th July 2016 in her cell. The death was caused or contributed to by metabolic derangement caused by profuse vomiting on the 19th July 2016 which was a consequence of undertreated withdrawal from opiates and alcohol. Her Majesty's Chief Inspector of Prisons published a report dated the 13th April 2016 in respect of HMP Bronzefield. The inspection which informed the report was undertaken between the 9th and 20th November 2015. Inspection of health care services was jointly undertaken by the Care Quality Commission and HM Inspectorate of Prisons. The report raised concerns about the non-administration of medication, failure to follow up non attendances by prisoners for medication and failures to keep accurate and complete medical records. The Deputy Head of Healthcare at HMP Bronzefield gave evidence on the 30th November 2018 that the prison still has no formal process in place by which to know if critical medicine is being given on time. There is also no evidence to suggest that any formal auditing of clinical records in the prison has taken place since 2015.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. – 1. The prison officer with responsibility for the wing on which Miss Chin was resident was not privy to what medication she was prescribed nor when it should be administered. There is no system in place for consent to be obtained from prisoners for this information to be shared with discipline staff. 2. The Sodexo Justice Service Protocols in respect of opiate and alcohol withdrawal did not adequately mirror the National Protocols and were, in parts, unclear and difficult to comprehend. 3. Nurses failed to make any datix referrals in respect of missed medications. 4. The following matters have to date not been formally audited by Sodexo Justice Services:

	i.) Whether prisoners who do not attend for prescribed medications are followed up and the reason for non-attendance is properly recorded. ii.) Whether critical medication is administered on time. iii.) Whether proper observations are undertaken in line with national or local protocols in respect of opiate and alcohol withdrawal. iv.) Whether medical records on System 1 are accurately recorded. v.) Whether the Patient Guidance Directions in respect of prescribing by nurses are adhered to, and whether medical records are checked before any prescriptions are made by nurses pursuant to the directive. 5. As a consequence it is not possible for Sodexo Justice Services to know whether the matters raised in 4.(i) to (v) have been adequately addressed. 6. The response by Sodexo Justice Services to the issues identified in the report dated the 13th April 2016 of Her Majesty's Chief Inspector of Prisons in respect of non-administration of prescribed medication was inadequate. It does not appear that there was a clear line of governance in respect of this matter. 7. Whether there is adequate training: i.) of discipline and clinical staff, including agency staff, to make them aware of the signs and dangers of opiate and alcohol withdrawal. ii.) of clinical staff in respect of the completion of opiate and alcohol withdrawal scales.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation has the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 7th March 2019. I, the coroner, may extend the period. Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.

8	**COPIES and PUBLICATION** I have sent a copy of my report to the following: 1. [redacted] 2. [redacted] 3. [redacted] 4. [redacted] 5. [redacted] 6. [redacted] 7. [redacted] 8. [redacted] 9. [redacted] 10. The Chief Coroner I am also under a duty to send the Chief Coroner a copy of your response. The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**Signed:** **Caroline Topping** **Dated this 10th January 2019.**