Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Ms Amy Cross, a prisoner at HMP Eastwood Park, on 10 June 2023

A report by the Prisons and Probation Ombudsman

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OUR VISION

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

WHAT WE DO

WHAT WE VALUE

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.

If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Ms Amy Cross died on 10 June 2023 at HMP Eastwood Park after she was found unconscious in her cell. The post-mortem concluded that the cause of her death was the consequences of chronic alcohol misuse with sudden cessation of alcohol consumption. She was 31 years old. I offer my condolences to Ms Cross' family and friends.

Ms Cross had only been at Eastwood Park for around three hours before she died. Upon her arrest, Ms Cross was drowsy and intoxicated. Her care after this point was complicated because she came into contact with three different healthcare providers during her time in custody, who do not use the same systems to record clinical information.

Relevant medical information was not shared appropriately between the police, Serco, and the healthcare team at HMP Eastwood Park. Had the digital Person Escort Record been completed and shared as intended this would have resulted in a better continuity of monitoring Ms Cross' alcohol and drugs withdrawal symptoms.

However, Eastwood Park provided effective care for Ms Cross and did their best to meet her needs and manage her withdrawal symptoms appropriately during her exceptionally short time in their care.

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

Adrian Usher
Prisons and Probation Ombudsman **July 2024**

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Summary

Events

1. Ms Amy Cross was arrested on 9 June 2023 for possession of a controlled drug. In police custody on the morning of 10 June, a healthcare practitioner assessed that Ms Cross was withdrawing from drugs and alcohol and gave her detoxification medication (to lessen her withdrawal symptoms).

2. Later that morning, Serco escort officers took Ms Cross to court for her hearing. The digital Person Escort Record (PER) that travelled with her to court did not record that she had been prescribed detoxification medication.

3. At court, Ms Cross was remanded to HMP Eastwood Park. Prior to her departure, at the request of Serco, a healthcare practitioner employed by Aeromed assessed Ms Cross, as she presented with withdrawal symptoms. The healthcare practitioner identified that Ms Cross might be dehydrated (because she had been vomiting) but considered that she displayed no signs that she was withdrawing. She gave Ms Cross anti-sickness medication. The PER was not updated with this information.

4. Ms Cross arrived at Eastwood Park at 3.30pm. During her reception screening, the GP diagnosed Ms Cross with opioid and alcohol dependency and prescribed her methadone and alcohol detoxification medication. (Ms Cross was due to receive her medication during the evening medication round, which started from around 5.30pm.)

5. At 6.49pm, when an officer went to unlock Ms Cross from her cell to collect her detoxification medication, she found her unresponsive. She immediately alerted a nurse and called the emergency alarm. Staff did cardio-pulmonary resuscitation (CPR) until the paramedics arrived. The paramedics declared that Ms Cross had died at 7.37pm.

6. The post-mortem concluded that the cause of Ms Cross' death was the consequences of chronic alcohol misuse with sudden cessation of alcohol consumption.

Findings

7. When Ms Cross was seen by the Serco healthcare practitioner at court, they did not adequately update the PER with the medical treatment that she received. This meant that the medical information passed on to Eastwood Park was not as accurate as it should have been.

8. Although Ms Cross had some risk factors for substance misuse when she arrived at Eastwood Park, we consider that her needs were appropriately assessed, and she was supported during her short time at the prison.

Recommendation

- The Serco Contract Director for Prisoner Escort and Custody Services (PECS) must ensure that information is recorded in a detainee's PER after every significant interaction, including any medical treatment given.

The Investigation Process

9. The PPO was notified of Ms Amy Cross' death on 12 June 2023. 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. No one responded.

10. The investigator obtained copies of relevant extracts from Ms Cross' prison and medical records, CCTV and body worn video camera (BWVC) footage. He also obtained the HMPPS Early Learning Review, Serco's internal investigation report, police custody records and Southwestern Ambulance Service records.

11. The investigator interviewed seven members of staff at Eastwood Park in August 2023. He also interviewed two members of staff by telephone and video conference in September and October 2023.

12. NHS England commissioned a clinical reviewer to review Ms Cross' clinical care at the prison. The clinical reviewer and investigator jointly interviewed staff.

13. We informed HM Coroner for Avon of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

14. We contacted Ms Cross' mother to explain the investigation and to ask if she had any matters that she wanted us to consider. Ms Cross' mother asked about the circumstances that led to her daughter's death.

15. Ms Cross' mother received a copy of the initial report. She pointed out two factual inaccuracies. This report has been amended accordingly.

16. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out five factual inaccuracies, and this report has been amended accordingly.

Background Information

HMP Eastwood Park

17. HMP Eastwood Park is in Gloucestershire and holds adult women. It has ten residential wings, two of which provide specialist substance misuse services. Healthcare services at Eastwood Park are provided by Practice Plus Group (PPG) who partnered with Avon and Wiltshire Mental Health Partnership NHS Trust, who provide psychosocial and mental health services.

HM Inspectorate of Prisons

18. The most recent inspection of HMP Eastwood Park was in October 2022. Inspectors noted that 83% of women reported that they suffered from mental health difficulties, and that many were caught in a cycle of homelessness, drug or alcohol misuse and offending. This made for a challenging environment which required highly skilled professionals to provide support for those in their care. The effect of staff shortages however, meant that the already curtailed regime was often further restricted and some of the consistency of provision and support that was essential in providing for this population, was not in place. Inspectors noted that women's prisons thrive when staff had time to build strong, professional relationships with the prisoners. The staff shortages meant that this was sometimes just not possible.

19. Inspectors found that health services were generally well led. Women arriving at the prison with a substance misuse concern were seen promptly by the psychosocial substance misuse team for a full assessment, and their care was reviewed by a doctor within 24 hours so opiate substitution therapy (OST) could be administered where appropriate.

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 2023, the IMB reported that the reception area staff were extremely helpful, calm and professional to those coming in and time was taken to carefully explain all stages of the reception process and to make sure it had all been understood. The complexity of prisoners' respective needs was prioritised. The majority of women entering the prison were tested for drugs. Mandatory drug testing (MDT) targets were met. However, a variety of illicit drugs appeared to be available on some wings.

Prisoner Escort and Custody Services

21. The Prisoner Escort and Custody Services (PECS) is part of HMPPS and contract Serco to provide court custody and escort services. This includes transportation between police custody, courts and prisons. Serco contract Aeromed Medical professionals to provide healthcare services within courts.

Previous deaths at HMP Eastwood Park

22. Ms Cross was the fifth prisoner to die at Eastwood Park since July 2020. Of the previous deaths, two were self-inflicted and two were due to natural causes. There are no similarities between these deaths and that of Ms Cross.

Key Events

9 June 2023

Police custody

23. At around 2.00pm on 9 June 2023, police arrested Ms Amy Cross on suspicion of possession of a controlled drug (they found a small amount in her possession at arrest). They took her into police custody at Torquay Police Station. At the time, she also had two outstanding warrants for her arrest. Ms Cross was described as intoxicated and drowsy. Police fully searched Ms Cross but found nothing further.

24. A nurse assessed Ms Cross and noted she had a history of alcohol and drug misuse, was dependant on and currently prescribed methadone. The nurse noted that Ms Cross had drunk alcohol in the last 24 hours. They requested that police staff collect Ms Cross' methadone from her nominated pharmacy, and noted that she required food, fluids and rest. Ms Cross was placed on 30-minute checks. The nurse did not prescribe any medication for alcohol withdrawal.

25. Police records noted that at around 3.43pm, two police officers visited Ms Cross' nominated pharmacy to collect her methadone. However, they were informed that Ms Cross had been banned from the shop some time ago, for shoplifting, and they therefore would not provide any medication for her.

26. At 4.46pm, the police told Ms Cross that she would not face any charges for possession of a controlled drug (due to the small amount found on her person when arrested). However, because she had two outstanding warrants (for possession of an offensive weapon and drug offences), she would still have to attend court.

27. The healthcare provider at Torquay Police Station does not provide a 24-hour service. As Ms Cross required checks because of her medical risk due to alcohol and heroin dependency, she was transferred to Exeter Police Station at 4.47pm, where this service is provided.

10 June 2023

28. On 10 June around 7.00am, Ms Cross said that she had vomited and felt unwell. A paramedic, using a Glasgow Modified Alcohol Withdrawal Scale (GMAWS) assessment tool, noted that Ms Cross had moderate alcohol withdrawal symptoms. A Clinical Opiate Withdrawal Scale (COWS) assessment was also completed and indicated that Ms Cross had moderate opioid withdrawal symptoms. The paramedic noted that Ms Cross was withdrawing from drugs and alcohol and prescribed dihydrocodeine (for opiate withdrawal symptoms) and diazepam (for alcohol withdrawal symptoms). A care plan created instructed that Ms Cross should be monitored for ongoing withdrawal symptoms.

Exeter Magistrates Court

29. To aid communication of prisoners' risks between criminal justice agencies, a digital Person Escort Record (PER) is completed for every prisoner who is securely

transported between police stations, courts, and prisons. The police will generate the PER for prisoners in their custody. Relevant staff access the PER on handheld devices (like a large mobile telephone). Serco escort staff access the PER on a device known as a VERA (Vehicle Escorting Recording Application), and court staff access the document on a device known as a CORA (Court Observations Recording Application).

30. At around 9.13am, the police handed over Ms Cross to Serco's care. Serco transported Ms Cross from Exeter Police Station to Exeter Combined Court, arriving at 9.26am. The PER that travelled with her to court (completed in police custody) noted that Ms Cross had a history of concealing drugs and was dependant on drugs (heroin) and was prescribed methadone. Staff added that Ms Cross was '*not taking methadone as not allowed script*'. It also noted that a healthcare professional had seen Ms Cross while in police custody on 9 June. The PER did not mention that Ms Cross was dependant on alcohol and no details were recorded of the medications that Ms Cross had been given in police custody.

31. Serco provided the investigator with their investigation report following Ms Cross' death. The report noted that during the journey from the police station to court, CCTV (from the escort vehicle) showed that Ms Cross vomited. Ms Cross told Serco custody officers that she had stomach pains due to alcohol withdrawal. This information was handed over to the Court Custody Manager (CCM) upon arrival.

32. Although the time is unknown, the CCM contacted Aeromed, the medical advisory service contracted by Serco, and asked them to assess Ms Cross as she appeared unwell, was withdrawing, looked thin and drained of energy. The CCM did not update the PER with this information.

33. At 11.57am, Ms Cross appeared in court and was remanded to HMP Eastwood Park to return to court later that month. Serco escort officers took Ms Cross back to a court holding cell to await transportation to Eastwood Park.

34. At approximately 1.30pm, according to the Serco records (Part B Prisoner Activity Log' document held on the VERA electronic system), the Aeromed healthcare practitioner arrived at court. The nurse assessed Ms Cross in the holding cell with two Serco officer's standing in the doorway. At interview, the nurse told us that she had been informed that Ms Cross was withdrawing (from an unspecified substance) but was not given any further information, including that Ms Cross had been seen by a healthcare professional in police custody that morning, and given medication to assist with opiate and alcohol withdrawal symptoms.

35. Ms Cross told the nurse that she had been sick twice and had smoked heroin the previous day. The nurse completed Ms Cross' clinical observations which were all within the normal range. She told us that she thought that Ms Cross may have been slightly dehydrated because she had vomited but she displayed no visible signs that she was withdrawing from any substances. She completed a COWS assessment that indicated that Ms Cross presented with medium to low withdrawal symptoms. She did not conduct an alcohol withdrawal scale assessment. She told us that she asked Ms Cross about her alcohol use, and she denied any issues. She prescribed Ms Cross cyclizine (an anti-sickness medication) and omeprazole (used to treat indigestion, heartburn, and acid reflux) for her stomach upset. She told us that she did not have any immediate acute clinical concerns about Ms Cross.

36. While information about the nurse's clinical assessment and the medications she had prescribed were recorded on the Serco Part B Prisoner Activity Log, the PER was not updated with this information.

37. After Ms Cross was seen by the nurse, Serco escort staff agreed to wait (for around 30 – 40 minutes) for her medication to start working, before taking her to Eastwood Park.

HMP Eastwood Park

38. At 2.00pm, Serco escort officers transported Ms Cross to Eastwood Park, arriving at 3.30pm. Serco's prison custody officer (PCO) told us that he told the prison reception staff that Ms Cross had been sick, was withdrawing and had been seen by a medical professional at court and given medicine to help with her sickness. He said Ms Cross had slept most of the journey to Eastwood Park. Ms Cross had been given a drink of water but declined any food.

39. The PER that travelled with Ms Cross recorded that she had alcohol and drug dependency and was a heroin and methadone user. It said that Ms Cross was seen by a healthcare professional in Exeter Police Custody on 9 June. No further details about this were recorded.

40. An officer recorded on the prison case management system that she interviewed Ms Cross in reception. She noted that Ms Cross was showing signs of withdrawal and described the interview process as difficult, although Ms Cross tried her best to answer all questions. Ms Cross said that she felt like "shit" because she was withdrawing. She denied any history of attempted suicide or self-harm and said she had no thoughts to harm herself. Ms Cross was offered a cup of tea, food and issued some vapes. She was offered a phone call but refused.

41. A paramedic completed Ms Cross' initial healthcare reception screen. Using the recognised withdrawal assessment tools, she noted that Ms Cross had mild alcohol withdrawal symptoms, had a dependence on alcohol and had mild withdrawal symptoms from opiates. Ms Cross told the paramedic that she had last used heroin the day before she came into custody. Ms Cross tested positive for opiates, cocaine and benzodiazepines. Ms Cross told the paramedic that she felt unwell due to having withdrawal symptoms, and that she had been sick prior to her arrival to Eastwood Park. She said that she took methadone in the community. When the paramedic contacted the community pharmacy to check this, they told her that Ms Cross' methadone prescription had not been administered to her since April 2023, because she had been banned from the pharmacy. During the review, Ms Cross did not disclose any significant medical history and denied that she had any thoughts of suicide or self-harm. The paramedic referred Ms Cross to the GP to review what medication she required due to her opiate and alcohol withdrawal symptoms.

42. At 4.33pm, CCTV shows Ms Cross was located on Kinnon Unit, which is a dedicated induction and detoxification unit (sometimes referred to as Residential Unit 8). Staff gave her a sick bowl because she continued to state that she felt sick. In his police statement, an officer said that he had known Ms Cross from previous stays in custody at Eastwood Park. He said she looked unwell when he saw her and was carrying a sick bowl in her hand.

43. On Kinnon Unit, healthcare observations are completed twice a day (typically in the morning and evening) or more frequently, for five days, dependent on the severity of a patient's symptoms or clinical presentation. Ms Cross was not due to have any further withdrawal observations until the next day.

44. At 4.34pm, a Healthcare Assistant (HCA) collected Ms Cross from her cell and escorted her to her video appointment with the GP. Ms Cross walked unaided to the clinic room holding the sick bowl.

45. During the consultation, Ms Cross told a prison GP that she had been arrested the previous day and had had no medication in custody. Ms Cross provided no medical history. The GP identified that Ms Cross looked unwell and was retching. She completed a withdrawal assessment that indicated that Ms Cross presented with moderate withdrawal symptoms. The GP diagnosed Mis Cross with opioid and alcohol dependency and prescribed her an increasing titration dose of methadone, and a seven-day alcohol detoxification regime. (Ms Cross would receive her medication during the evening medication round, which commenced from around 5.30pm.)

46. At 4.42pm, an officer escorted Ms Cross back to her cell. In his police statement, the officer said that Ms Cross' medication was not ready yet and she would be able to collect it later from the hatch. At 4.59pm, CCTV shows movement in Ms Cross' cell through her observation panel.

47. A Custodial Manager (CM) arrived for duty on Kinnon Unit at 5.00pm. She told us that she received a handover from the officer who told her that Ms Cross had recently arrived, was located in cell K2-35 and that her medication was not yet ready. She told us that it was not unusual for the medication for a new prisoner to not be ready immediately to be collected and staff would sometimes wait until the end of the medication round to collect that individual to attend the medication hatch.

48. As part of her cleaning job, Prisoner A handed out hot water (for tea) to prisoners on the unit. At 5.25pm, she knocked on Ms Cross' cell door and looked through the observation panel and asked her if she wanted any hot water. In her police statement, she said that Ms Cross was lying on her bed, facing the opposite wall, where the TV was located, but did not respond.

49. At 5.30pm, the medication rounds began. Staff knocked on each prisoner's cell door to ask them if they were due to collect medication. Prisoners who needed medication were then unlocked so that they could collect it from the medication hatch.

50. At 6.09pm, Prisoner A again went to Ms Cross' cell and asked her if she wanted any hot water through the observation panel. Ms Cross did not respond. The prisoner noted that Ms Cross had changed position on her bed and was no longer facing the opposite wall, but the wall to the side of her bed.

51. Around 6.42pm, a nurse told an officer that Ms Cross had not received her medication yet and she should be brought to the medication hatch to collect it.

Emergency response

52. At 6.49pm, the officer went to Ms Cross' cell. When she looked through the observation hatch, she noticed that Ms Cross was on her bed with her arms propped over her head. Although she thought Ms Cross was breathing lightly, she did not look well and was unresponsive when called. The officer was concerned about Ms Cross' welfare and ran across the corridor to the healthcare team's office (approximately seven metres away) to request assistance. (Healthcare staff are permanently situated on Kinnon Unit).

53. An HCA attended in seconds, unlocked and entered Ms Cross' cell. When he checked Ms Cross, she was unresponsive, not breathing and grey/purple in colour. She had also vomited on the floor. The HCA immediately left the cell to obtain further healthcare support and medical equipment. He told us that he told the officer to call a code blue emergency (indicating that a prisoner was having difficulty or had stopped breathing). The officer radioed a code blue. Control room staff recorded that this happened at 6.50pm and telephoned for an ambulance immediately.

54. The HCA and a nurse returned to Ms Cross' cell in less than 20 seconds with an emergency medical bag and started cardiopulmonary resuscitation (CPR) with the use of a medical airway and defibrillator. Two officers also responded to the emergency alarm and assisted healthcare staff by rotating CPR. At 7.06pm, ambulance paramedics arrived, and staff moved Ms Cross into the corridor to gain better access to treat her. The paramedics took over the care of Ms Cross. At 7.37pm, paramedics confirmed that Ms Cross had died.

Contact with Ms Cross' family

55. When Ms Cross arrived at Eastwood Park, she did not provide any details of her next of kin. After extensive searching, Eastwood Park found Ms Cross' mother's telephone number. A Senior Officer (SO) (who had been appointed as the family liaison officer) attempted to call Ms Cross' mother several times throughout that afternoon and evening, without success. After several attempts, she left a voicemail message that requested that Ms Cross' mother contact the prison.

56. On 11 June, Ms Cross' mother contacted the prison and explained that she was on holiday abroad and that was why she had not responded. The next day, the Governor managed to speak to Ms Cross' mother and broke the news of her daughter's death. Eastwood Park contributed to Ms Cross' funeral costs in line with national instructions.

Support for prisoners and staff

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

58. After Ms Cross' death, the staff involved in the incident were given the opportunity to discuss any issues arising and were also offered support by the staff care team.

Post-mortem report

59. The post-mortem concluded that the cause of Ms Cross' death was the consequences of chronic alcohol misuse with sudden cessation of alcohol consumption.

Findings

Clinical care

60. The clinical reviewer noted that the healthcare Ms Cross received at Eastwood Park was of a reasonable standard and therefore equivalent to what she would have received in the community. She noted that the clinical management of Ms Cross' alcohol withdrawal in Eastwood Park was in accordance with PPG's standard operating procedure for 'assessment and management of alcohol dependence' (2021). However, the clinical reviewer raised concerns about the lack of communication between police custody staff, Aeromed, Serco and healthcare staff at Eastwood Park.

Identification and assessment management of withdrawal symptoms

61. When the Aeromed nurse examined Ms Cross at court, she was not aware of her medical history or that she had recently been given medication in police custody.

62. The Aeromed nurse told us that there was currently no formal process in place to ensure Aeromed clinicians knew that a person had been given treatment by another agency, unless Serco escort staff verbally handed this information over to her. The nurse told us that she did not have access to the PER, although on this occasion, we note that even if she had, it had not been completed sufficiently in police custody, and there was no information about the medication Ms Cross had been given. The lack of a formal process for sharing clinical information poses a significant risk because Aeromed healthcare professionals are making clinical decisions without obtaining relevant past and recent medical history.

63. Furthermore, the Aeromed nurse told us that Aeromed assessments are recorded on an electronic (medical) database which Serco staff do not have access to. As a result, the treating clinician must give a verbal handover to Serco staff on the medical treatment or advice provided to a prisoner. The clinical reviewer noted that this also posed a clinical risk because the handing over of clinical information to non-clinical staff meant information could inadvertently be misunderstood. This was evidenced by the documentation that Serco completed which indicated that the Aeromed nurse had given Ms Cross medication for "*withdrawal".* However, this was not the case, as the medication was prescribed to simply treat the nausea and vomiting that Ms Cross said she had been experiencing.

64. The Royal College of Psychiatrists (RCPSYCH) guidance for '*detainees with substance use disorders in police custody: guidelines for clinical management'* (2020) recognises that transitions to, from, and between, criminal justice settings such as police custody to courts and to prisons can create a potential for interruption of medication. It highlights the importance of ensuring there are effective channels of communication between all agencies within the criminal justice system. It states that if a detainee is transferred to court, and subsequently to prison, a copy of the medical record form should be sent with them. Any medication prescribed should be entered on the form with confirmation of the time the medication was dispensed to the detainee. This did not happen in Ms Cross' case on the PER.

65. The Deputy Head of PECS told us that the healthcare contract Serco have with their healthcare provider states that "There may be healthcare information contained within the Person Escort Record (PER) which may be relevant to the Prisoner's care whilst in court detention which should be given due regard. Healthcare staff will contribute to the accurate completion of risk documentation and records including the PER, to provide details of assessment and any interventions provided."

66. Clearly this did not happen in Ms Cross' care. The Deputy Head told us that Serco are currently working towards giving Aeromed nurses access to the PER. We make the following recommendation:

The Serco Contract Director for Prisoner Escort and Custody Services (PECS) must ensure that information is recorded in a detainee's PER after every significant interaction, including any medical treatment given.

Withdrawal Management

67. The Aeromed nurse assessed that Ms Cross did not present with any withdrawal symptoms for alcohol. However, she did not use a formal alcohol withdrawal clinical assessment tool, such as a GMAWS, to aid her clinical decision making.

68. If the Aeromed nurse had known that Ms Cross had been given alcohol withdrawal medication in police custody and had been made aware of the previous GMAWS, this might have prompted her to use an alcohol assessment tool during her consultation or at least ensured there was greater clinical justification recorded for why further alcohol withdrawal medication was not given.

69. The British National Formulary (BNF) recommends a long-acting benzodiazepine for alcohol withdrawal symptoms, including diazepam, which Ms Cross was given in police custody at around 7.00am. It also recommends that further reducing doses should be given over seven to ten days, but this is dependent on the person's presentation and severity of withdrawal symptoms. Treatment should only continue as long as the person presents with withdrawal symptoms. As the Aeromed nurse told us that she did not believe Ms Cross presented with alcohol withdrawal symptoms, her decision not to give alcohol withdrawal related medication at this time, was in line with prescribing guidance.

Medical risk management at Eastwood Park

70. Ms Cross was only at Eastwood Park for just over three hours before her death. The PER provided to staff in reception did not give any detail about the assessment and treatment she had received in police custody, nor the assessment and treatment given to her while she was in court. (Prison staff do not have access to the Serco Part B Prisoner Activity Log document held on the VERA electronic system.)

71. Nonetheless, clinical observations completed for Ms Cross upon her arrival at Eastwood Park were within a normal range. Given how Ms Cross presented during the reception assessment and during the consultation she had with the GP, the clinical reviewer had no concerns that her clinical observations were not repeated during her short time in custody. Healthcare staff told us that clinical observations can be taken at any time at the discretion of healthcare staff, but the clinical

reviewer was satisfied that there was not an immediate clinical indication to take Ms Cross' clinical observations again outside of the planned times.

72. Furthermore, the GP who assessed of Ms Cross at around 4.30pm deemed that she did not require medication immediately and prescribed it to be given to her during the normal medication rounds on the Kinnon Unit (which typically started at 5.30pm). Staff went to collect Ms Cross at the end of the medication rounds at 6.49pm.

73. From interviews, we were told that healthcare and prison staff could request that a prisoner was given their medication sooner if there were concerns about their presentation. As none of the prison or healthcare staff had any additional concerns about Ms Cross' presentation, this did not happen. The clinical reviewer concludes this was a reasonable decision in the circumstances.

Head of Healthcare to note

74. It was well documented that all the agencies that had come into contact with Ms Cross had known that she had vomited a number of times, which is a symptom of both alcohol and opiate withdrawal. When someone is vomiting due to alcohol withdrawal there is a risk that they can become severely dehydrated, which can then lead to further serious medical complications.

75. The clinical reviewer noted that while it may be more difficult to expect staff at Eastwood Park to monitor a person's fluid intake and output than in a hospital environment, it would have been helpful for Eastwood Park to have increased Ms Cross' clinical assessment and monitoring of her levels of hydration. The Head of Healthcare should consider including within their withdrawal observation policies, a specific process to support and guide healthcare staff on how to assess and monitor a patient's level of hydration in the event of prolonged vomiting or diarrhoea due to withdrawal.

Learning outside our remit: Police custody

76. Ms Cross' period in police custody is not within the remit of this investigation. In police custody on 10 June, a paramedic gave Ms Cross medication for both alcohol and opiate withdrawal symptoms. When she was handed over to Serco, who escorted her to court, the PER stated that she had been seen by a healthcare professional in police custody but did not record any specific details of that assessment, including the medication that she had been given. We consider that the information passed from the police to Serco escort staff on the PER did not adequately reflect Ms Cross' risk due to her drug and alcohol dependency. We passed on our concerns to the police, but they did not confirm whether they were completing an investigation into Ms Cross' care.

Inquest

77. An inquest was concluded on 29 September 2025, that the cause of Ms Cross' death was from natural causes due to consequences of chronic alcohol misuse with sudden cessation of alcohol consumption.

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