Investigation into the circumstances surrounding the death of a woman at HMP & YOI Styal in April 2008

Report by the Prisons and Probation Ombudsman for England and Wales

November 2008

This is the report of an investigation into the death of a woman who died in April 2008 at HMP & YOI Styal. The woman had been received into prison on 11 April, having been sentenced to four months imprisonment by a Magistrates Court. She had a history of substance misuse, which included both alcohol and illicit drug abuse.
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A post mortem was held at the request of HM Coroner for Cheshire, Halton and Warrington. It concluded that the woman's death was due to natural causes, resulting from a subarachnoid haemorrhage secondary to a ruptured berry aneurysm. I extend my sincere condolences to the woman's partner, son, mother, family and friends.

This investigation was undertaken by one of my investigators. I would like to thank the Governor of Styal and his staff for their help and assistance. I am also grateful to the prison's liaison officer for her help during our inquiries.

A review of the woman's medical care at Styal was commissioned by Central and Eastern Cheshire Primary Care Trust. A doctor carried out this review on behalf of the Trust and I am particularly grateful for his thorough and detailed findings.

I make three recommendations for the attention of Central and Eastern Cheshire PCT and the Head of Healthcare in relation to practices and services within Styal, and note four further recommendations within the clinical review. I make two recommendations and one housekeeping point for the Governor for support to staff following a death in custody. Lastly, I commend both healthcare and uniformed staff for their actions immediately following the woman's collapse.

This final report includes comments made by the Governor of Styal in response to the issues section in the draft report. A sub section heading has been amended to Incentives and Earned Privileges and, included in that section is additional commentary by the Governor. A revised explanation of the work of Listeners has also been amended.

Stephen Shaw CBE
Prisons and Probation Ombudsman **November 2008**

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SUMMARY

The woman was sentenced to four months imprisonment on 11 April 2008 at a Magistrates Court. She was received into Styal where her initial health screening noted her alcohol and substance misuse.

Later that day, a cell risk sharing assessment was started. The woman was unwell during the assessment and it was noted that she had some suicidal thoughts and could get frustrated. An Assessment, Care in Custody and Teamwork (ACCT) document was opened. (The ACCT process is a system of casework, support and care for the monitoring of prisoners judged to be at risk of self-harm or suicide.) Following a medical examination, the woman was placed in the First Night Centre (FNC) on a detoxification regime.

On 12 April, the woman saw a Senior Officer (SO) who reviewed the cell risk sharing assessment. The SO recorded that the woman had been issued with a warning for poor behaviour the previous evening. She was suffering the effects of withdrawal despite being prescribed medication to help her symptoms. The woman told healthcare staff she did not like detoxing and found the process traumatic.

The woman remained on the FNC for the first phase of her detoxification and attended the Substance Misuse Clinic. She remained on an ACCT with regular reviews and was seen by healthcare staff to check her blood pressure, pulse rate and general health.

On 16 April, the woman transferred from the FNC to Waite Wing. She was still experiencing detoxification symptoms and attending the Substance Misuse Clinic. A week later, her ACCT document was closed following a review meeting. The woman told the panel she was feeling much better. On 24 April, she transferred to Wilson House where she shared a room with two other prisoners.

At about 8.00pm on 26 April, the woman was associating with other women in Wilson House, when she went to a cupboard in her room and was seen to fall to the floor by one of her room mates. The room mate shouted for help and the house alarm was raised. Two officers from a nearby house block responded to the alarm, shortly followed by two nurses. One of the nurses assessed that the woman was unconscious and incontinent of urine. The nurse requested further assistance and an emergency ambulance.

At 9.07pm, the woman was transferred to an ambulance, taken to hospital and placed on a life support machine. A Release on Temporary Licence was completed by Styal's Duty Governor, and the woman's partner was contacted by Police.

The woman died at 1.20am on 28 April without regaining consciousness.

THE INVESTIGATION PROCESS

1. The investigation into the woman's death was opened by one of my investigators on 14 May 2008. The Ombudsman's terms of reference and notices of investigation was sent to the prison in advance of Ms Gilbert's visit. The notices were displayed for prisoners and staff. No one came forward in response to those notices.

2. My investigator reviewed the woman's prison files and visited Wilson House, a dormitory style residence, where she had collapsed on the evening of 26 April.

3. Between 10 and 12 June, my investigator returned to Styal and interviewed two officers and one prisoner.

4. One of my Family Liaison Officers (FLO) wrote to the woman's brother with information about the investigation and explained our wish to include the family's issues. This was followed up by a number of telephone calls, but my FLO was unable to speak to the woman's brother directly. A copy of this report will be sent to her family.

4. **HMP & YOI STYAL**

5. HMP Styal began life as a children's home in 1898. It was then used to house refugees, before finally opening as a women's prison in 1962. In April 1999, Styal's population increased by 60 per cent following the change of role from a training prison to a local prison, and the closure of the women's wing at HMP Risley. Today it has an operational capacity of 455 prisoners.

6. Styal is the only local prison for women covering the North West and North Wales. It mainly holds short term sentenced prisoners and those on remand awaiting trial. The prison also has a small number of prisoners serving indeterminate sentences. Approximately 3,000 women are received through its gates every year.

7. Styal is essentially two prisons within one perimeter. The accommodation is divided into 16 Victorian houses or villas on one side, and a conventional prison block (Waite wing) on the other. The houses provide shared accommodation for more trusted sentenced prisoners and are self-contained. There are lower levels of staffing and no staff on duty during the night.

8. The healthcare unit does not provide in patient care. A doctor is based in healthcare during the daytime and evening. Nurses are based in the unit on 24 hour call.

9. Since my office took over the investigations of deaths in custody there have been four self inflicted deaths and one other death due to natural causes at Styal. The death of The woman had no similarities to the other natural cause death.

10. After a full unannounced inspection of the prison in October 2005, a report by HM Chief Inspector of Prisons, Ms Anne Owers, said:

    "Styal has undoubtedly moved on, and is a safer and better prison than it was; and this is a credit to both managers and staff, who deal daily with a very damaged, and growing, population. But it is as yet unable to meet the needs of that population or of women in the north-west region."

    Since this investigation started a further inspection of Styal has been undertaken. At this point, the report from Her Majesty's Chief Inspector of Prisons has not been published.

11. The Annual Report for 2007 by the prison's Independent Monitoring Board included this judgement in its summary:

    "The turnover in healthcare staff continues to cause problems for the health care manager, who juggles staffing problems along with the other pressing issues presented by such a needy population. The appointment of Central and Eastern Cheshire PCT as Commissioners should hopefully resolve the worst of these staffing problems within the next year."

KEY FINDINGS

12. On 11 April 2008, the woman was sentenced to four months imprisonment by a Magistrates Court. On her reception into Styal, she was seen by a nurse and a healthcare screening document was completed. The document noted that the woman showed signs of withdrawal from alcohol and illicit drugs. She had regularly used heroin and cocaine and was alcohol dependent. A urine test confirmed traces of benzodiazepine, cocaine and opiates. It was further recorded that the woman had long-standing depression, and asthma, and was concerned about the results of a recent cervical smear test. Her blood pressure reading was 127/78 (within the normal range of 120/80) and her pulse rate was 67 beats per minute (within the normal range of 60-100 beats per minute).

13. A cell sharing risk assessment was completed and the officer noted that the woman was "currently being sick in reception so unable to interview". The assessment also noted that she did have suicidal thoughts and could get frustrated. An Assessment, Care in Custody and Teamwork (ACCT) document was opened. Later, the woman said she had no thoughts of self-harm or suicide, but had self-harmed during a previous custodial sentence. Further documentation noted the next of kin details of her partner.

14. Later that day, the woman was transferred from reception to the First Night Centre (FNC) and was seen by a doctor. On examination, the doctor noted signs of drug withdrawal. (The woman was frequently being sick with visual signs of withdrawal.) The doctor prescribed Methadone (an opiate substitute) and Librium (a drug used to help alleviate withdrawal symptoms). All medication was held by healthcare and dispensed to the woman by nurses.

15. The next day, a cell sharing risk review was completed by a Senior Officer (SO). The SO noted that the woman had been abusive, and was issued with a warning resulting in the loss of association for poor behaviour. Later the woman was seen by a member of the prison's mental health in-reach team. She refused a mental health screening and said she had no thoughts of self-harm. The same day, she was examined by a nurse and her notes recorded a blood pressure reading of 123/74 and pulse rate of 93 beats per minute. The woman was suffering from blurred vision, sneezing and insomnia, although she told the nurse she was feeling better than the previous day. The woman continued to take her Methadone and Librium and was referred to Substance Misuse Clinic.

16. On 13 April at 9.20am, the SO and an officer carried out an ACCT assessment interview with the woman for her ACCT review. The SO noted that the woman was having difficulties coping with detoxification. She had received a warning for demanding her medication and had covered up the cell door observation panel so staff could not see her. This warning meant the woman lost her association time for 24 hours.

17. The woman had also threatened to commit self-harm. A care map plan was completed. (A care map plan is a part of the ACCT documentation that outlines actions that help the prisoner to achieve positive targets with the help of staff. This plan is discussed with the prisoner and it includes support from staff to help

achieve those actions). The woman was to continue with her current detoxification, speak to staff if she felt unhappy, and consult with a member of healthcare about her cervical smear test. Her next ACCT review was scheduled for 23 April.

18. Later that day, the woman was examined by a nurse. Her blood pressure reading was low (110/73) and pulse rate (101 beats per minute) was slightly high. The woman told the nurse she felt unhappy and was unable to go on association as she had received a warning for anti-social behaviour. (This warning had been noted on the woman's ACCT document.) She also confided in the nurse that the previous evening she was looking at ways to hang herself as she did not like detoxing and found it very traumatic. The nurse gave the woman her medication, together with paracetamol for a headache. Later it was noted on her medical notes that a nurse was unable to complete a set of clinical observations as she was "behind her door" (loss of association due to a warning.)

19. The following day (14 April), the woman's General Practitioner (GP) was contacted by a member of the healthcare staff for a copy of her prescribed medication whilst in the community. A fax was received from the GP confirming the woman's medication. There is no record in her medical notes of any clinical observations taken that day.

20. The woman's observations were taken on 15 April. Her blood pressure was 139/79 and pulse rate 79 beats per minute, within normal range. She still felt unwell, had a slight tremor and told the nurse she had vomited twice during the night. The next day, the woman's observations were recorded as blood pressure 89/63 and pulse rate 63 beats per minute, lower than normal range. She refused to attend the Substance Misuse Clinic and the offer of a hepatitis B vaccination. Another appointment was made for her to attend the clinic. Later that day, the woman transferred to Waite Wing.

21. On 17 April, the woman attended her appointment at the Substance Misuse Clinic. The nurse noted that she had been using illicit drugs and large amounts of alcohol in the community. The woman told the nurse that she was still withdrawing, and her symptoms included double vision, slight tremors, diarrhoea, and insomnia. The nurse suggested that her methadone should be increased and an extended regime of Librium offered to help with the alcohol withdrawal symptoms. The woman told the nurse that she felt low but had no suicidal or self-harm thoughts. A care plan was completed by the nurse and the woman's medication was reviewed by the doctor. The doctor added Diazepam (a sedative used to relieve anxiety). The woman was advised to carry on with an extended Librium regime and increased dosage of 35mls Methadone.

22. Later that day, the woman attended an appointment at the Genito-urinary Clinic. The nurse and the woman discussed her recent abnormal cervical smear test. The woman told the nurse she would ask a relative to bring in her hospital letter. She also gave permission for the nurse to contact the hospital where she had been referred prior to her imprisonment. The nurse noted the woman had decided to remain on her original dosage of 30mls of Methadone. The nurse

discussed this with her team leader. They agreed that the woman could remain on 30mls Methadone and be supported by the substance misuse team.

23. The woman collected most of her medication in the morning of 19 April. She refused her Librium saying that she had been sick during the night, but would have it at lunchtime. Over the next two days, the woman continued with her medication, but did not attend a healthcare appointment as she had a visit from her partner.

24. Three days later, the woman completed phase one of her detoxification regime (phase one is the first week of detoxification where there is higher support and medication) and moved to phase two (the second stage of detoxification requiring less medication). Her observations were noted as blood pressure 117/65 (low) and pulse rate 117 (higher than normal).

25. On 23 April, the woman was examined in healthcare by a nurse. Her blood pressure reading was 117/77 (again low) and pulse rate 113 beats per minute (high). At 11.15am, an ACCT case review was completed with the woman present. The ACCT panel did not include any representative from healthcare staff. Present at the review was a senior officer, a wing officer and the woman. She told the review panel she had problems with her detoxification when she came into prison but now felt much better. The ACCT document was closed and the post closure interview was scheduled for23 May.

26. The next day, the woman did not attend the healthcare unit for a blood test, but no reason was recorded for the missed appointment. The same day, she moved from Waite Wing to room three in Wilson House, a dormitory style house block where she shared the room with two other prisoners. Two days later, it was recorded in her medical notes that she did not attend an appointment at the Genito-urinary Clinic. Again, it was not recorded in the woman's notes why she did not attend this appointment. Another appointment was re-listed for her.

27. At about 8.00pm on 26 April, the woman went into her room on the first floor of Wilson House. A prisoner was sitting in the room, writing. The prisoner told my investigator she could hear the woman rustling in the wardrobe and presumed she was looking for her tea-making kit. The prisoner turned around to speak to her when she saw her fall to the floor. Her first thought was that the woman was 'messing around', but then realised she had collapsed. There was no response when the prisoner spoke to her and the woman had urinated. The prisoner immediately shouted for help. Another prisoner responded to the shout and pressed the house alarm bell. (There were no staff on duty in the house at this time.)

28. A second prisoner in Wilson House, answered the prisoner's shout for help and went into room three. There she saw the woman lying on the floor, holding a plastic bag in her hand. The second prisoner saw that the woman was staring with her eyes open, but there was no response when she spoke to her. The second prisoner helped move the woman into the recovery position and put a pillow under her head.

29. Two officers were in Bruce House, close to Wilson House, and responded to the alarm call. On entering Wilson House, a prisoner directed the officers upstairs into room three. When the officers entered room, they saw the woman lying on the floor with the two prisoners beside her. As soon as one of the officers bent down to look at the woman, she immediately called for a code blue (medical emergency) over her radio. The officer then asked for the prisoners to leave the room so she and the other officer could assess the situation. One of the officers told my investigator that the woman was breathing and making a groaning noise, but did not respond to questions. Two more officers arrived, shortly followed by two nurses.

30. One of the nurses examined the woman and found that she was unresponsive, incontinent of urine and her immediate thought was that she might have had an epileptic fit. She requested further assistance from healthcare staff, and asked one of the officers to use her radio to ask the communications room staff to call an ambulance. The communications room asked the officer to use the landline, as they required more information. The officer went to telephone in the house office. One of the nurses also used the telephone to ask for information regarding the woman's medical history. The nurse attending to the woman asked an officer to contact the nurse in the office, to get some rectal Diazepam (used to prevent prolonged seizures). The officer went to the office and was followed by another officer, who said the rectal Diazepam was needed immediately. The officer passed this message to the nurse and returned to room three.

31. A few minutes later, two more nurses arrived with an emergency bag (which contains all the equipment needed for a medical emergency). An officer then assisted other officers to lock the Wilson House prisoners into one of the dormitories. When she returned to room three, the officer saw the nurses were preparing to move the woman into a position where there was more space.

32. During this time, a number of alarm bells were activated in other houses within the prison grounds. Officers were diverted to attend to the alarms instead of assisting and supporting colleagues at Wilson House. It was later found that there were no emergencies in the houses and staff had been misled.

33. The nurse attending to the woman noted that the woman's pupils were fixed and dilated, and inserted an airway tube into her throat. She was unable to detect a pulse. Two nurses then commenced cardio pulmonary resuscitation (CPR).

34. At 8.23pm, a first response paramedic arrived and assisted the nurses with CPR. Around 8.35pm, the ambulance arrived and three paramedics joined their colleague. The paramedics then took over CPR from the nurses and continued with emergency treatment. The CPR appeared to have some impact and an entry on the woman's medical record by a nurse noted, "at this stage there was good cardiac output and breathing, although she remained unresponsive, and her pupils remained dilated". The nurses and paramedics discussed the woman's recent medication recorded from her medical history sheet.

35. At 8.50pm, the woman was transferred to the ambulance by the paramedics. The ambulance was then delayed as paramedics continued to stabilise her

condition. At 9.07pm, the ambulance left the prison with two officers. No restraints were applied. The ambulance arrived at a hospital at 9.25pm and the woman was taken to the Accident and Emergency Department.

36. The prison did not have a telephone number for the woman's next of kin. A governor made contact with Police and asked them to attend an address of the woman's partner. The police visited the address but he was not at home. The police asked a friend to pass on a message to make contact with them. The woman's son was believed to be in Spain, and there were no contact details for him. The woman's partner was later informed by the police of her admission to hospital.

37. A hot de-brief for prison staff involved in the woman's emergency was held at midnight. The duty governor and a member of the prison's staff care and welfare team led the de-brief, which was concluded at 0.23am on 27 April. One of the officers was told she could report for duty later that day instead of 8.00am.

38. At 1.00am, a governor completed a release on temporary licence (ROTL) form for the woman. Medical staff at the hospital had notified the prison that the woman was on a life support machine and an escort was inappropriate. It was recorded in the bed watch notes that her partner had telephoned the hospital and they had advised him to attend as his partner's condition was serious. At 1.30am, the officers left the hospital.

39. During the morning, a governor spoke to the woman's partner by telephone and arranged for a taxi to take him and a friend from their home to the hospital. Later, police contacted the prison and told the governor that they were pursuing other enquiries into the woman's next of kin. A previous address had been checked for the whereabouts of her son but they had failed to locate him.

40. On 28 April at 1.20am, the woman died with her partner at her bedside.

41. With the assistance of police, the woman's brother was located and informed of his sister's death by the local police. The woman's brother said that he would relay the news to his sister and elderly mother. The prison's Family Liaison Officer attempted to contact the woman's partner during the day. He eventually spoke to him at 6.47pm when he told the Family Liaison Officer that he had been in touch with the woman's brother and told him of his sister's death.

42. During the course of that day, an officer who present when the woman collapsed was supervising a medication queue when a prisoner told her of the woman's death. Prisoners in Wilson House had been asked to meet in the lounge area and were told of the woman's death by a member of the senior management team. Prisoners were offered support from staff and the use of the Listener scheme if they needed it. (Listeners are volunteer peer supporters selected, trained and supported by Samaritans, using the same guidelines, to listen and offer emotional support, in complete confidence, to their fellow prisoners who may be in crisis, feel suicidal or who need a confidential sympathetic ear.)

43. On 30 April, the Family Liaison Officer and the Governing Governor visited the woman's brother at his home. The Governor offered assistance towards the woman's funeral expenses and the Family Liaison Officer supported the family with the organisation of the service.

44. On 12 May, The Family Liaison Officer, a staff member and a representative from chaplaincy attended the woman's funeral service.

ISSUES

Incentives and Earned Privileges

45. The woman was warned about her poor behaviour shortly after arriving in the First Night Centre (FNC). Staff used the red tick system (a prisoner receives a red tick for each episode of indiscipline). After receiving three ticks the prisoner receives an Incentives and Earned Privilege (IEP) warning. (IEP warnings are given when a prisoner fails to adhere to standards of behaviour or performance.) The woman was given three red ticks and lost a 24 hour period of association during her first days of detoxification. This minimised the opportunity for easy observation of her condition.

46. Prison Service Order (PSO) 4800 says:

    "If for any reason a woman undergoing detoxification is located other than in the stabilisation unit or healthcare centre, the healthcare must meet the same criteria as if she were located in a substance misuse or healthcare unit i.e. unrestricted observation and a nurse based on the unit 24 hours a day."

47. Whilst the FNC has dedicated healthcare staff on duty, on 13 April a nurse noted in the woman's medical record that she was unable to complete observations as The woman was not on association time and was remaining in her room. The following day, there is no record on her medical notes of any observations by healthcare staff.

48. A previous death in custody, presently under investigation at Styal, also found that a prisoner with withdrawal symptoms on reception was issued with a warning and loss of association. It is entirely right that staff should not expect to be subject to verbal abuse or threatening behaviour. Nevertheless, when women are undergoing the traumatic physical symptoms of withdrawal, they should think twice before issuing IEP warnings.

49. The report into the woman's death will be circulated before the report referred to above. I would ask the Governor to give this matter his serious consideration.

50. In response to the draft report, the Governor has commented that the recording of the woman's observations of blood pressure readings, temperature and pulse rate, by the nurse, should not have been hindered by her loss of association due to the IEP warning. It was the view of the Governor that this was a misunderstanding which he will address.

51. The Governor further commented that in the guidance of PSO 4000 (Incentives and Earned Privileges) chapter three, paragraph 3.22, advice is given that local schemes do not penalise behaviour, which is a direct consequence of a disability, particular age, or need. The definition of disability covers mental impairment.

52. The term mental impairment is wide ranging and includes impairment because of drug or substance abuse. Prisoners under going withdrawal symptoms will suffer some mental impairment. The Governor noted that some serious consideration

would be given to this point and the use of the IEP system. However, the Governor concluded that there was a clear expectation that withdrawal could not be used to mask inappropriate behaviour of prisoners.

Clinical Care

53. A clinical review of the woman's medical care was commissioned from Central and Eastern Cheshire Primary Care Trust (PCT). A doctor carried out the review on behalf of the PCT.

Substance Misuse

54. The doctor noted that the woman's reception screening recorded her substance misuse, mental health problems and asthma. Healthcare staff assessed her risk of self-harm and this information was made available to prison staff who opened up an ACCT form. The woman's asthma did not require any medication at this point, and the doctor has said that the woman's needs were correctly assessed on reception into Styal.

55. In relation to the management of the woman's substance misuse, the doctor has judged that, during her first phase of detoxification, she should have had ten sets of observations taken (two to three times a day) instead of the four recorded in her notes. The medical notes did not record whether the observations were correct or if a review of her medication should have taken place. The doctor further noted that the woman's detoxification regime was not reviewed for six days. Whilst there was planning to manage her withdrawal symptoms, there was no evidence that they were adequately assessed and controlled. I endorse the following recommendations:

The Head of Healthcare should ensure that all prisoners who are on either a substitution or a detoxification regime have their observations taken in line with protocol and report the outcome of audits of this matter to the PCT.

The Head of Healthcare should ensure that staff are adequately trained to assess the significance of the observations taken on patients who are on substitution and detoxification regimes. The staff should also be trained to take the appropriate action with referral to the doctor where appropriate.

The PCT and the Head of Healthcare should ensure that an audit of the adequacy of the symptom control of patients on substitution and detoxification regimes is undertaken. The outcome of the audit should be compared with the findings of a similar audit of patients undergoing treatment in community settings. The audit should also look at the environment in which substitution/detoxification is undertaken.

Record Keeping and Self Harm Management

56. Record keeping in the woman's medical notes did not state whether her observations were satisfactory in relation to her detoxification. The doctor has commented that there is a need to ensure that prisoner's clinical observations are

taken when necessary and in line with medical practice. The woman's risk of self-harm was assessed but the notes are unclear as to whether they were accurate as there is no recognised structure to assess the risk of self-harm. Whilst she was on an ACCT, the clinical notes were unclear about the risk she posed to herself. The doctor could not find any evidence that healthcare staff are systematically trained in the assessment and management in the risk of self-harm, although staff may have basic knowledge of the issues. It appears the woman was managed appropriately using the ACCT system. However, I am disappointed that no member of healthcare staff was present at the ACCT review which led to its closure. The doctor has written further about this in his clinical review which is annexed to this report.

Emergency response

57. The woman did not complain of any symptoms or show physical signs of the aneurysm that caused her death whilst she was in Styal, although she did complain of headaches. Headaches are a symptom of drug withdrawal. Her blood pressure readings were within normal to low range. (Elevated blood pressure readings can be an indication to the rupture of an aneurysm.) The doctor has assessed that healthcare staff acted appropriately and competently when the woman collapsed on 26 April.

I commend healthcare and prison staff for their actions immediately following the woman's sudden collapse.

Other healthcare issues

58. The woman was offered a vaccination for hepatitis B, which she refused, and her abnormal cervical smear test was being followed up. Copies of the woman's medical records were obtained from her General Practitioner.

59. There is evidence that the woman's failure to attend healthcare related appointments was managed correctly, with appointments being re-listed.

60. In conclusion, the doctor has commented as follows:

> "The condition which led to the woman's death could not have been detected in the absence of a combination of symptoms and clinical signs. Further to facilitate detection the symptoms would need to have been present for duration of time. I conclude that the woman's death could have not have been foreseen and therefore could not have been prevented."

61. Noted in the clinical review are six further recommendations for the attention of Central and Eastern Cheshire PCT, the Head of Healthcare and Governor of Styal. They relate to clinical services and practice, and I urge their acceptance.

Support for staff

62. Following the woman's collapse and subsequent transfer to hospital, the officers involved attended a hot de-briefing session at midnight on 26 April through to

0.23am on 27 April. A member of the prison's staff care and welfare team was present at the de-brief. The governor offered support to the officers and any ongoing help they might have needed. The officers then left the prison at about 0.35am. One officer was due on duty at 8.00am on 27 April, and was told by the governor that she could take some time off in the morning but report for duty before 1.00pm. The nurses who attended to the woman were not present at the de-brief.

The Governor should ensure that all relevant healthcare staff are included in hot de-briefs.

63. The officer reported for duty at 9.30am on 27 April and carried out her duties for that day. Her incident report form was not written until 1 May, when she was able to be supported by a representative of the Prison Officers' Association (POA). She was supervising a medication queue on 28 April, when a prisoner informed her of the woman's death.

64. The members of staff involved in the woman's sudden collapse should have been told of her death personally by a line manager, or a member of staff care and welfare team.

The Governor should ensure all staff involved in a like incident are told appropriately of the death of the prisoner.

65. A follow up review meeting with officers and nurses involved in the woman's collapse would have given an opportunity for those concerned to share their experiences with peer support. The tragic and unexpected death of prisoner affects individuals in different ways, in particular officers and nursing staff with limited experience of a death in custody. Whilst staff care and welfare was evident, the opportunity to discuss the circumstances surrounding the woman's death at a later date would have been useful for all those concerned. I suggest that a review meeting of all staff involved in an incident where a prisoner has subsequently died would offer peer support and an opportunity to raise any issues affecting individuals.

RECOMMENDATIONS

For the attention of Central and Eastern Cheshire Primary Care Trust and the Head of Healthcare

1. The Head of Healthcare should ensure that all prisoners who are on either a substitution or a detoxification regime have their observations taken in line with protocol and report the outcome of audits of this matter to the PCT.

   Accepted - "To be actioned immediately by the PCT provider and discussed at the November Partnership Board.

2. The Head of Healthcare should ensure that staff are adequately trained to assess the significance of the observations taken on patients who are on substitution and detoxification regimes. The staff should also be trained to take the appropriate action with referral to the doctor where appropriate.

   Accepted – " Training to be planned immediately by the PCT provider. Align to Integrated Drug Treatment Services (IDTS). A report to be provided to the Styal Partnership Board in November."

3. The PCT and the Head of Healthcare should ensure that an audit of the adequacy of the symptom control of patients on substitution and detoxification regimes is undertaken. The outcome of the audit should be compared with the findings of a similar audit of patients undergoing treatment in community settings. The audit should also look at the environment in which substitution/detoxification is undertaken.

   Accepted – Align with IDTS requirements. The Head of Healthcare and Lead PCT commissioner for drug services to plan and implement audit. Findings to be shared with the Partnership Board."

For the Governor of HMP Styal

1. The Governor should ensure that all relevant healthcare staff are included in hot de-briefs.

   Accepted – All staff are invited all ready. Styal will review how this is communicated to healthcare staff and monitor attendance."

2. The Governor should ensure all staff involved in a like incident are appropriately told of the death of the prisoner.

   Partially accepted – "Whist a consistent communication is clearly our aim it is almost impossible to prevent staff/prisoners informally communicating information to other. A notice was issued to all staff and posted at the gate overnight on 28 April so that all on duty staff would see this."

Good Practice

I commend healthcare and prison staff for their actions immediately following the woman's sudden collapse.

"A general notice to staff of the outcome of the Ombudsman's investigation will be published including a relevant statement from the Governor on the appropriateness of care given to the woman.

Housekeeping Point

A review meeting of all staff involved in an incident where a prisoner has subsequently died would offer peer support and an opportunity to raise any issues affecting individuals.

Accepted – "This approach has been implemented and the staff are asked how they wish to give feedback, either directly at a meeting with peers or informally in writing if they do not wish to attend."

ANNEXES

1. Documents considered during the investigation