

**Investigation into the circumstances surrounding the  
death of a woman  
at HMP & YOI Styal in January 2009**

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

This is a report into the circumstances surrounding the death of a woman, a prisoner at HMP Styal, in January 2009. She was found at approximately 6.30pm in her cell having hung herself. The officer who discovered her called for assistance, and staff and paramedics attempted resuscitation. She was pronounced dead by the prison doctor. She was 36 years old. I offer my sincere sympathy and condolences to her family and friends for their loss.

The investigation was carried out on behalf of the Ombudsman by my colleague. A clinical review of the woman's healthcare at Styal was undertaken by a clinical reviewer on behalf of the local Primary Care Trust. I am grateful for his review. I would also like to thank the Governor of Styal and his staff for their co-operation and assistance. Particular thanks go to a duty governor for her help throughout the investigation.

The woman had been in prison several times and suffered with drug addiction. She had just begun a short sentence at Styal and arrived with symptoms of drug withdrawal. She was withdrawing from drugs but staff did not consider her at risk of harming herself. She was confined to her cell because staff believed that she had brought drugs with her. While in her cell she hung herself.

The woman did not give any indication that she was likely to harm herself. She had made plans for a visit and told staff of her desire to find somewhere to live. However, she felt unwell due to the pain of her drug withdrawal and it is possible that this led to her actions.

I make three recommendations.

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

**Jane Webb**  
**Prisons and Probation Ombudsman**

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## **SUMMARY**

The woman was born in July 1972. She was arrested in January 2009, and sentenced to 28 days in prison the following day.

Upon arriving at Styal, the woman went into the toilets with another prisoner. Staff noticed cigarette smoke and followed the two women. They suspected her of bringing drugs into the prison and confined her to her cell for the next 24 hours.

The woman was unwell due to withdrawing from drugs and considered the amount of methadone she was given insufficient. Despite her discomfort, staff told my investigator that they did not consider her to be particularly unwell compared to many of the women in Styal.

The woman hung herself at some point between 5.15pm and 6.30pm in January. She was found by an officer who immediately called for assistance. Cardio pulmonary resuscitation (CPR) started quickly and continued until the paramedics arrived and took over. The prison doctor declared that she had died. Prison staff contacted her family and broke the news of her death.

The woman never gave anyone the impression that she might harm herself. Although she was in discomfort due to withdrawing, the conversations she had with staff included plans for the future.

I make three recommendations in this report. They include issues that the Ombudsman has raised in other investigations at Styal. They relate to detoxification and the issuing of Incentive and Earned Privilege (IEP) warnings.

## THE INVESTIGATION PROCESS

1. The investigation into the woman's death was opened in January 2008 by an investigator and the Deputy Ombudsman. They met senior managers at the prison and collected the woman's prison records. Notices of the investigation had already been sent to the prison but no-one came forward in response.
2. The investigator wrote to the local Primary Care Trust requesting a review of the woman's clinical care in custody. The clinical reviewer was provided with a copy of the medical records from the prison and relevant interview transcripts.
3. The investigator and an Assistant Ombudsman visited Styal in March to interview staff and prisoners. The investigator returned later in March to conduct further interviews.
4. One of the Ombudsman's family liaison officers contacted members of the woman's family. They felt strongly that she would never have intentionally left her daughter. They described her as a strong person who had dealt with difficult events in her life. They said she had spoken positively about the future and intended to find somewhere for her and her daughter to live. The family felt these were not the actions of someone who intended to take their own life. They said that the only possible explanation was that she experienced too much pain from withdrawing from drugs. Her family raised the following issues:
  - How was her detoxification being managed?
  - She asked for more drugs to help her cope with the pain she was experiencing whilst detoxifying. Why were they refused?
  - Why was it considered appropriate for her to have items which could be used to harm herself?
  - Why was it considered appropriate to restrict the association of someone undergoing detoxification?
  - Why was she not considered to be at risk of harming herself?
  - Why was her partner told of her death by telephone?
5. Following the publication of the draft report, the woman's family responded with their comments on the report. I have included reference to these views in this version of the report. I hope this report offers some answers to their questions.

## **HMP & YOI STYAL**

6. Styal opened as a women's prison in 1962, having previously been a children's home and refugee centre. It increased in size by over 60 per cent in April 1999 due to its transition to a local prison, and the closure of HMP Risley. (A local prison serves the courts in the area, and generally only holds prisoners for short periods of time.) It currently has a capacity of 460 prisoners and receives women from the North West and North Wales.
7. When women arrive at Styal they receive a Level A search. This is a fully clothed rub-down search that includes the hair and facial area. It is followed by a search with a wand that identifies any metal objects. A full search can be authorised by any prison officer if they have intelligence that the prisoner may be attempting to smuggle contraband into the prison and does not happen routinely.

### **First Night Centre (FNC)**

8. All women who come to Styal first stay in the First Night Centre (FNC). The FNC is in a building called Oak House and it has space for 25 women in single, double or four-bed rooms. Each FNC room on the FNC contains a television, wardrobe, and a safe for locking away any valuables. There are no safer cells on the FNC. (Safer cells have specially designed furniture and fittings to reduce the number of ligature points.)
9. The regime on the FNC is more relaxed than on the regular wings. The women are unlocked at 7.45am and largely remain out of their cells all day apart from a short period over lunchtime. The women are checked hourly in their cells throughout their first night. They stay in the FNC for at least 48 hours and a number of assessments, including those by healthcare and substance misuse professionals, are carried out.

### **Incentives and Earned Privileges Scheme**

10. Women at Styal who commit minor acts of indiscipline, exhibit anti-social behaviour or fail to adhere to the required standards of behaviour or performance can be issued with an Incentives and Earned Privilege (IEP) warning. IEP warnings are issued at the discretion of officers and are used as a tool to address prisoners' behaviour. The warning operates under a "tick/point system". The women receive nine points each week and these points can be added to or lost by the issue of positive (green) or negative (pink) warning slips. One or more ticks can be received for each episode of indiscipline. If a woman receives three ticks on one or two warning slips she is punished by the loss of association for 24 hours which starts from 4.00pm the following day. Loss of association means that women remain in their room and are not allowed to mix with other prisoners. At the time of the woman's death the punishment had to be authorised by the group manager in the relevant area. The women maintain their other privileges, such as keeping the television in their cell.

## **Independent Monitoring Board**

11. Each prison has an Independent Monitoring Board (IMB) made up of members of the community. The Board's role is to ensure that the prison is properly run and that prisoners are treated decently. Each Board produces an annual report for the Secretary of State. The IMB has a large presence at Styal with 17 members. The IMB representative that my investigator talked to spoke of their good relationship with senior managers and the considerable efforts made by staff to care for prisoners. The Board noted that the amount of self-harm in the FNC had reduced, but commented that it was still an area where the availability of drugs caused concern.

## **Her Majesty's Chief Inspector of Prisons**

12. Her Majesty's Chief Inspector of Prisons inspected Styal in September 2008. In her report she noted the challenging population in Styal, with over 33 per cent saying they had felt depressed or suicidal, over 40 per cent with health problems and over 50 per cent with drug problems. The report stated that considerable effort was made to meet the challenges but "in spite of these admirable efforts, the prison was not able to meet the scale and complexity of need". However, the report noted that "the Prison Service has yet to recognise the level of resources needed to allow prisons like Styal to manage and care for these women appropriately".
13. The report described reception and first night arrangements as "mostly good", although it noted that "many women in our survey said they had felt unsafe on their first night". The report pointed out that, despite three further self-inflicted deaths since the previous inspection, little had been done to develop action plans. It commented on the well integrated drug strategies and early intervention of the CARATs service.
14. The report stated that "some sanctions [under the Incentives and Earned Privileges scheme] such as stoppage of association were implemented without appropriate authority or review and decisions were not always based on patterns of behaviour". Staff were described as unsure of the system which led to some inconsistencies and there was no evidence of management checks to ensure consistency and fairness. The Chief Inspector said that there were many examples where women lost association due to a single episode of negative behaviour. The report recommended:
  - Prisoners should not lose association or receive other unsanctioned punishments as a result of incentives and earned privileges warnings.
  - Regular management checks should be conducted to ensure that warnings issued are fair and consistent.

## **Previous Ombudsman's reports into deaths in custody at HMP Styal**

15. Before the Ombudsman's office was given the responsibility of investigating all deaths in prison custody in April 2004, there were a series of six self-inflicted deaths at Styal between August 2002 and August 2003. The

Ombudsman personally investigated the last of these deaths and reviewed the others. Between April 2004 and January 2009 when the woman died there were three more self inflicted deaths at Styal. The office has also investigated two natural cause deaths at the prison. The death of one of these other women also occurred on the First Night Centre. She had not been considered at risk of harming herself when she apparently took her life. One of the other women who died had also lost her association on the day of her death.

## KEY FINDINGS

16. The woman was born in July 1972 and had a daughter. She had a longstanding drug problem which caused her to be arrested on numerous occasions.
17. In January 2009, the woman was arrested by police at 9.55pm and taken to the local police station. She was assessed at 10.14pm as being at medium risk of harming herself and described as fit and well with no apparent injuries or ailments. She told the police that she was a heroin and methadone user and last used drugs at approximately 8.00pm. She said that she would cope that evening but might need something in the morning to prevent her withdrawing. She met a drugs worker at 11.54pm.
18. The woman was charged with theft and failing to appear in court. She was seen by the doctor at 1.09am who confirmed that she was fit to be interviewed and go to court, but noted that she may start to withdraw if she was detained after 10.00am. Her risk of harming herself was noted as standard (the lowest level). She left the police station at 7.14am to go to the Magistrates Court. A police officer wrote that the woman had drug/alcohol issues on the Prisoner Escort Record. She was sentenced to four weeks in jail and arrived at Styal early that evening and was taken to the reception area.
19. The woman and another prisoner went straight into the toilets. (The prisoner later told the police that they met on the transport van. The woman told her that she had some drugs concealed on her that they could take when they got to the prison.) When they were in the toilet cubicle, the prisoner told my investigator that she rolled a cigarette because the woman said that she had not smoked in several days. The woman removed a plastic 'Kinder Egg' holder that she had concealed. Staff were alerted to the cigarette smoke and went into the toilet. An officer described what she saw:

“... as I went in the toilet they were smoking, I can't remember if I saw a cigarette now or not, I can't remember without checking on paperwork. But the woman had a 'Kinder Egg' in her hand, also her trousers were near her knees, she was stood up with another prisoner very close, obviously up to no good ... “
20. A Senior Officer (SO), and two officers separated the women in order to carry out a full search, which involved removing their clothes. The searches revealed burnt foil and the plastic Kinder Egg holder. The SO told my investigator that, given their behaviour, it was her belief that the women had taken some drugs.
21. The prisoner was sure that she never actually saw any drugs in the toilet and did not know what happened to them after staff entered. However, she explained to my investigator that she was certain that the woman had some drugs when she came to Styal.

22. Bringing drugs into prison is a serious breach of prison rules. The staff decided to issue the woman and the prisoner with an Incentives and Earned Privileges (IEP) slip with three ticks on it. This indicated the offence was anti-social and against prison rules. The usual process would be for the slip to be collected by the IEP clerk who would pass it to the duty governor to decide the appropriate punishment.
23. However, in this case the slip was never actually filled out. The first officer believed the SO had done so, and the SO believed the opposite. The SO decided that the woman should lose her association and stay in her cell for 24 hours, starting immediately. (This was not complete confinement as she would be allowed out for an hour the following morning to collect her medication and have a shower.) The woman would have contact with staff as they made their routine checks of the First Night Centre (FNC). The SO explained that the punishment was intended to protect the other women on the FNC. As either the woman or the prisoner might have drugs concealed within them, the officers decided that they could not allow them to mix with the other women in case they passed drugs to them.
24. The reception process at Styal includes several meetings with prison staff to assess immediate needs and risk. If a woman is initially categorised as not a high risk to herself or others, she can be taken to the FNC. (This allows the other assessments to be carried out in a quieter environment.) The first officer undertook the woman's Cell Sharing Risk Assessment (CSRA) after the incident in the toilet and judged her to be at low risk of harming others.
25. The officer also completed the first part of the Immediate Needs Assessment with the woman. She told the officer that she was on drugs but did not harm herself. The officer described her appearance as: "just normal withdrawing, nothing extreme. She answered the questions easily, she was not in pain or anything". The woman was taken to the FNC and the officer told the staff about the punishment that she had incurred.
26. All women receive a healthcare reception screening when they arrive at the prison. A nurse assessed the woman at approximately 8.00pm. She told the nurse that she was a smoker and poly-drug user but did not intend to harm herself. (Polydrug use is the use of more than one drug, often with the intention of enhancing or countering the effect of another drug.) The nurse recorded that her daily drug use was "3-5 bags of heroin daily, 60 mls of methadone bought off the street, 20 mgs of Benzodiazepines and 3-5 bags of cocaine daily".
27. A drugs screen showed, that the woman tested positive for opiates and cocaine. The nurse told my investigator that she seemed content and gave no indication that she might harm herself. The nurse made a reference on the computer: "no thoughts of deliberate self harm". The woman's blood pressure was recorded as 99 over 81 which did not concern the nurse, although she noted that her weight of 43kg was quite low.

28. The woman saw the prison doctor who confirmed her dependence on drugs and prescribed a methadone stabilisation plan. (This is a regular daily dosage of methadone aimed to remove the craving for opiates. A detoxification prescription is different as it gradually reduces the methadone dosage to zero. For women on short sentences, such as the woman, there is often insufficient time for a detoxification prescription.) She was given 10mgs of methadone at 9.45pm that evening. This amount of methadone is normal at the start of a methadone programme as it minimises any possibility of an accidental overdose.
29. The woman was placed in cell 5 on the FNC. It is a double room but she was the only occupant. (It was explained to the investigator that this was not unusual as the location of the women depends on the number in the FNC.) The first officer had already told the wing officer that she had lost her association privileges for 24 hours. The woman telephoned a friend in the evening and complained of withdrawing from drugs. The conversation suggested that she asked her friend to smuggle drugs into the prison during a visit the following day. She claimed that she was not given anything to alleviate her withdrawal symptoms.
30. The woman slept until 5.30am the next morning and then asked for more medication. She complained that she felt unwell an hour later. She was given her breakfast and then allowed out of her cell at approximately 8.45am for an hour's association. She was given a second 10mgs of methadone at 9.05am. Whilst she was out of her cell, she saw the prisoner. The prisoner told my investigator that the woman appeared to be withdrawing and had told her that she felt really ill. The prisoner explained that the woman was a heavy drug user and it was the prisoner's personal opinion of detoxification that the 10mgs would not have been sufficient to relieve her symptoms.
31. The woman met a CARATs worker that morning. (CARATs (Counselling, Assessment, Referral, Advice and Throughcare) work with prisoners with drug problems. The women are assigned workers who support them through their sentence.) She told the CARATs worker that she was prescribed 10mgs of methadone and felt very unstable. The CARATs worker said that, although the woman said she felt ill, this was not uncommon among the women she saw on the FNC. She explained that the woman expressed an interest in working with the CARATs team, and was scheduled to have been taken on to their workload during the next week.

32. The woman also underwent a First Night Centre interview in the late morning with the Probation Service Officer. He reviewed the CSRA assessment and the woman repeated that she did not have any feelings of self-harm. She told him that she had a daughter and explained the caring arrangements for her. He had no concerns about her physical or mental well-being. He described their conversation:

“I saw no issues at all with the woman. When we were actually talking about the offence she actually said to me almost light heartedly that another reason that she was in is that she’d done a breach by missing an appointment. To which I said to her it was very unlikely that she would be breached for missing a single appointment and almost jokingly she kind of said ‘well OK it was three interviews that I missed’. So she was almost, not light hearted and joking, but there was certainly no suggestions of anything, any issues with her at all.”

33. The Probation Service Officer said that the woman made no comment about the level of her methadone prescription to him:

“No, she just related that this was the dosage that she was on when she came in. As I say she, you quite often get the feeling with some of the lasses when they’ve come in if they’ve been on a higher dose and they’ve come in, they’ve gone on a lower dose. They can be a little bit shaky or a little bit upset but the woman didn’t show any signs of anything like that.”

34. The woman received a Hepatitis B vaccination at approximately 10.50am she refused a mental health assessment an hour later saying that she had no mental health issues.
35. An officer found her in another woman’s room having a chat and locked her in her room at approximately 11.00am. The woman had been out of her cell for more than an hour because staff were busy with medication and day-to-day tasks. She did not present any concerns and seemed to accept her loss of association well. The officer remembered that she complied and immediately returned to her room.
36. The wing officer saw the woman a number of times over the next few hours as she completed various tasks on the FNC. The woman asked if she could have a telephone call, and later said she felt ill and “10mls was not enough to hold me”. The officer took her lunch up to her at 12.00pm. The woman asked for help with her pin telephone application, and the officer explained the form to her. (This is the method by which prisoners are allowed to make telephone calls.) The officer told my investigator that although the woman looked as though she was withdrawing, this was not unusual on the FNC.
37. The officer told the Healthcare Assistant (HCA) that the woman felt unwell. The healthcare assistant said that the woman would be given another 10mls of methadone that evening. The officer went to see the woman to tell her and the woman gave her the pin phone application and a letter. According to the

officer, the woman accepted the information about the medication calmly although she did make another reference to 10mls not being enough.

38. The officer read the woman's letter. (My investigator was told that all mail from the FNC is read before it is posted.) The officer later had a call from the security department who expressed concerns that, having listened to the woman's telephone conversation the previous evening, it was clear that drugs were to be brought in on a visit. The officer believed that an under-lined part of the letter might be a code relating to smuggling of drugs during visits. She told the security department about her suspicions.
39. The woman spoke with one of the FNC orderlies through her door. (An orderly is a prisoner who works in the prison.) The orderly remembered that the woman looked ill and had asked her if she "could get her anything". The orderly assumed that this was a reference to illicit drugs, and told her that she could not get her any.
40. The woman's blood pressure was taken at 2.55pm by the HCA which was 102/68 with a pulse of 72. My investigator was told that these blood pressure and pulse readings were within normal range for someone of the woman's lifestyle. (It was also noted that she was showing visual signs of withdrawal.) The HCA went through a series of documents with the woman:
  - The first was the prison's Substance Misuse Clinical Assessment. The HCA explained that the document records the drugs (and amounts) that the woman used in the community. It also covers various risk factors concerning their drug usage.
  - Second the Opiate Withdrawal Monitoring Chart allows the prisoner to grade the severity of their withdrawal symptoms on a level of nought to three. The HCA said that the form relied on what the woman told her. The HCA pointed out that the woman graded her nausea/vomiting as three, but there was no evidence that she had been sick at any point.
  - The third document was the Benzodiazepine Withdrawal Scale which allows the woman to grade the severity of their symptoms on a scale of nought to four. The HCA noted that the woman scored herself a total score of 62. However the healthcare assistant did not think that this accurately reflected her appearance and the HCA would have expected someone with that score to look worse than she did.
  - Finally the Drug Intervention Record provides an overview of the woman's drug history. The woman said that, as she was of no fixed abode, she would need help with accommodation when she was released. She explained that she had been a drug user since the age of 14 and spent up to £250 a week on drugs.
41. Although the HCA thought the woman was coping better than she claimed, she suffered some withdrawal symptoms including cramps. The HCA asked a second HCA to request a prescription of Quinine to alleviate her leg cramps. A prison doctor wrote the prescription although the woman died before she received the medication.

42. The woman's blood pressure was taken again at 4.12pm and it was 109/68 with a pulse of 67. My investigator was told that there was nothing in these readings that concerned the HCA. The healthcare assistant remembered that the woman was sitting up in bed during this examination and did not seem particularly unwell. She did not ask the HCA about extra methadone. The HCA said that she did not stand out as being particularly unwell compared to the other women in Styal. She had no concerns about her physical or mental well-being. She did not mention self-harm or suicide and gave the HCA no impression that she would consider either.
43. The woman's dinner was taken to her cell by the wing officer at 5.15pm as she was not allowed out of her room. The officer asked her if she was going to tidy her cell and, although they did not have a lengthy conversation, he said that she gave no indication that she was distressed. He remembered that she looked tired but said this was not unusual among women in the FNC.
44. Another officer went to make a random check of the woman's room at 6.30pm. When she looked into room 5 she saw her sitting in the space between the cell door and her bathroom door. She had a ligature around her neck made from her identity card lanyard which was tied to the bathroom door handle. A belt was also attached to the handle. The officer called for help and another officer left his post in the downstairs office and went to her assistance. She shouted to him that it was a code blue and he issued an alert over the radio. (A code blue alert is a medical emergency relating to breathing.)
45. The officer arrived at the room. They cut the ligature and laid the woman on the floor. Neither officer could find a pulse or a heartbeat and so they began cardio pulmonary resuscitation (CPR). The officer ran to get a protective face mask. As the second officer started CPR liquid came up into his mouth. He stopped CPR and rolled the woman over to help remove the vomit coming from her mouth. He then restarted CPR. An SO arrived and a Principal Officer followed shortly afterwards.
46. A nurse arrived first from the healthcare centre, which is located behind the FNC. The second HCA followed bringing the mask and oxygen. A senior nurse was also on her way when she heard a shout for a defibrillator. She turned back, collected it and went to room 5 with a prison doctor who also rushed over. The nurse noticed that the woman had no pulse and took over CPR. The defibrillator was attached but instructed staff not to shock her. (The defibrillator has an audio device which instructs staff on the procedures to be followed.) Neither the nurse nor the senior nurse could find any sign of life. The prison doctor pronounced that the woman was dead at 6.35pm.

### **Following the woman's death**

47. An ambulance was called by the OSG at 6.33pm and the paramedics arrived at 6.45pm. They left the cell shortly afterwards as the woman had already been pronounced dead. They went downstairs to talk to the nurses who had taken part in the resuscitation attempt. The care team had been informed and

were immediately available to offer support to staff involved in the resuscitation attempt. The nurse explained that additional healthcare staff came from Waite Wing which meant that the nurses involved were able to take a break for a few minutes.

48. The prison telephoned the Independent Monitoring Board (IMB) at 7.22pm. Two board members arrived at 7.50pm and 8.20pm. They went to the Command Suite to observe the crisis management but did not visit the First Night Centre. A governor was appointed Family Liaison Officer (FLO) at 8.00pm. The police arrived at 10.15pm and visited the woman's room. The police took witness statements from those involved, and left at approximately 3.30am. The prison staff left nine hours after the woman died, as they volunteered to stay in the prison until they completed their police statements.

### **Liaison with the woman's family**

49. The prison had difficulty in contacting the woman's next of kin due to the incomplete details she provided when she arrived at Styal. She had provided a mobile telephone number for her boyfriend, but no address as he was of no fixed address. The Deputy Governor telephoned his number at 8.30pm and told him that the woman had died. The prison was aware that the woman had a daughter and was keen to speak to her carer as soon as possible. The police agreed to go to her address and broke the news to her partner's mother, who was the primary carer for her daughter. The news was not broken until the early hours of 9 January.
50. The police also identified the telephone number for the woman's mother and the governor was able to contact her. The deputy governor (the governing Governor was on leave) and the prison FLO visited the woman's mother later that day. Her mother raised concerns about her daughter having a belt and ID lanyard in her possession. They were offered financial support for the funeral and the Governing Governor attended the woman's cremation.
51. The prison also telephoned all the other families who had previously lost family members at Styal and were still waiting for an inquest. They were told of the woman's death so that they did not hear about it from other sources.

### **Care for staff and prisoners**

52. A Principal Officer went over to the residential unit, Fox House, after the woman died to tell the FNC orderlies and Listeners so that they could be prepared to support the other women. (A Listener is a prisoner trained by the Samaritans to provide emotional support to other prisoners.) One of the FNC orderlies explained to my investigator that she was also offered support from the prison chaplain. The prisoner who came into the prison with the woman did not recall being offered any formal support, although she said that a staff member she worked with had helped her.
53. A healthcare debrief was undertaken at 7.20pm led by the then Head of Healthcare. A prison debrief was undertaken at 10.25pm which was chaired

by Deputy Governor. Healthcare staff were invited but they had already gone home when the invitation was issued. However, healthcare staff held their own debrief a few weeks later. The prison counsellor was available for all staff, and my investigator was told that several staff found this helpful.

54. The officer who attempted CPR went to hospital at approximately 7.30pm for a health check because of the vomit that had gone into his mouth. A member of the care team went with him. The officer told the investigator that he had to organise subsequent health tests himself as the prison did not have any procedures for such an event.
55. The prison FLO issued the Governor's Notices to Staff and Prisoners at 9.30pm informing them of the woman's death. The notice to staff was put on the gate and they could see it as they came into the prison.

## ISSUES

### Loss of association

56. The woman was suspected of taking drugs in the toilets. Staff could have chosen to deal with the matter through the adjudication system or the IEP.
57. The first option would have meant that staff placed her on report and requested an adjudication board to rule on the offence and decide on the punishment. A punishment of cellular confinement could be applied at an adjudication hearing after an examination of all the facts by a Governor. When such a punishment is imposed, sanctions to protect the safety of a prisoner are put in place, including regular checks, and a doctor assesses whether the person is capable of coping with such a punishment.
58. However, staff believed that there was an immediate threat of the passing and sharing of drugs. The adjudication board would not, and could not (due to certain procedures that need to be adhered to) sit immediately. Consequently staff decided not to use the adjudication system to deal with the alleged behaviour.
59. The second option was to use the IEP system. At the time of the woman's death Styal had a local IEP policy, designed in accordance with the National Framework and PSO 4000 and Prison Service Standard 25. The operation of the system is detailed below:
- “Each prisoner, regardless of regime will start the day with a notional score of 9 points. Prisoners can earn a maximum of 3 additional points for each credit issued. A score of 12 or over on a daily basis is indicative of enhanced status. Alternatively 3 warning slips would also trigger a review from enhanced to standard, or standard to basic.
- “When anyone issues either a credit slip or a warning slip they must place it in the appropriate IEP box positioned around the establishment ... The credit/warning slips will be collected by the collator at 12.00 hrs every day. Issued slips will be recorded on IEP cards.
- “Prisoners start each day with 9 points. Warnings on each of the areas of behaviour result in loss of points, i.e. 1 per area or six points or less will result in privileges not being earned on that day. Three warning sheets will result in a regime review and three credit slips will also result in a regime review.
- “Generally where a person scores 6 points or less they will not be able to earn association or TV. They will have to remain in their room for the particular evening. In non cellular accommodation the same will apply, however control cannot be policed in the same way.”
60. The intention was to issue the woman with an IEP slip with three ticks on it in order as punishment for the suspicion that she had brought drugs into the

prison. This was never actually completed. Had it been completed, the normal process was for the IEP clerk to collect the slip and pass it to the duty governor the next day in order for any action to be determined. The governor in charge of the IEP policy explained how the policy was not fulfilled:

“At the time ... there wasn’t duty governor approval for the IEP system. It should have been processed by the IEP clerk the following day and whether the manager concerned would have activated that loss of association would have been down to that manager.”

61. However, not only was the procedure not followed, the SO also decided to impose 24 hours immediate loss of association. The governor in charge of the IEP policy also explained how the removal of association on should have been managed:

“If a manager or member of staff are concerned that this person has secreted drugs, there’s a likelihood of them distributing or trading drugs on the First Night Centre, the decision then to remove them from normal association regime should have been the duty governor ... ”

62. My investigator found some uncertainty over the application of the IEP policy, which was reflected in the way it was applied to the woman. The Ombudsman has commented on the use of IEP warning slips in previous reports on deaths at Styal and am concerned that this confusion still appears to be present. The woman’s family also noted their concerns when responding to the draft report. I am told that the IEP policy is currently being reviewed, and I encourage the Governor to ensure that the new policy is well understood by all members of staff.

**The Governor should ensure sufficient training is carried out to enable all relevant members of staff to adequately understand the IEP policy.**

63. I am also concerned by the practice of confining someone who is withdrawing from drugs to their room for 24 hours. I know that this matter was of significant concern to the woman’s family as well, as they mentioned it again when responding to the draft report. The loss of association can be a severe punishment for women who are detoxifying. However, I also understand the importance of making every effort to prevent drugs being smuggled into prison. There is also a need to protect other women from being passed drugs. In the woman’s case, as she was allowed out of her cell for over an hour the following morning and was not stopped from spending time with the other prisoners, the loss of association does not seem to fulfil the intended purpose. The Substance Misuse Development Manager was also concerned:

“... it is not advisable to locate a woman who is withdrawing in isolation as this can precipitate their anxiety and stress in regards to withdrawing from substances and personal issues”.

64. I believe that the prison should think very carefully before imposing punishments in this manner. I appreciate that managers will want to empower

wing staff to make decisions about the women in their care. However I concur with the governor in charge of the IEP policy's view, that a decision to withdraw association like this, should be taken by a governor.

**The Governor should ensure that decisions about loss of association for women suffering drug withdrawal are taken by the duty governor.**

### **Clinical issues**

65. The clinical reviewer's overall opinion was:

"It is unarguable that the woman received a level and standard of care at HMP Styal which would be considered to be equivalent to the standard of care which she would have received had she consulted a relevant healthcare professional in the community."

66. However, the clinical reviewer made a number of recommendations that I would encourage the Governor and Head of Healthcare to seriously consider.

### **Detoxification and drug support**

67. The woman's family were concerned that she struggled to cope with withdrawing from drugs and wanted to know about the management of detoxification. She was a poly-drug user and was withdrawing from opiates when she arrived at Styal. The clinical reviewer stated:

"The woman's history of substance misuse was correctly identified by the healthcare staff at HMP Styal. The nature and extent of the substance misuse was also identified."

68. The woman was prescribed methadone to manage her withdrawal. In accordance with the prescription, she was given 10mls of methadone on the first evening and another 10mls the following morning. She made it clear to several members of staff that she did not feel that 10mls was sufficient to alleviate her symptoms. She complained that she felt unwell when she woke, again when she met the CARATs worker and also when she spoke to an officer at lunchtime. This third complaint prompted the officer to raise the issue with the HCA, who merely reported that she would get another 10mls that evening.

69. My investigator spoke to the Substance Misuse Development Manager about the potential flexibility of a methadone prescription. She explained that at the end of five days prescription for methadone there is an opportunity for the dosage to be increased if necessary. However, there is also flexibility during the first five days.

70. She said that if a woman is shown to be clinically withdrawing and is not stabilised on the standard methadone prescription, then a supplementary dosage of 10mls methadone can be added. The additional dosage can be administered six hours after the previous dose as long as it does not exceed

30mls in the first 24 hours in custody. The standard methadone stabilisation prescription currently includes an 'as required' 10 ml dose of methadone that can be given during the first night to deal with any withdrawal symptoms. The woman's family, when responding to the draft report, felt that all staff concerned with drug withdrawal should have been aware of the flexibility of the methadone prescription.

71. There was scope for the woman to be given an extra 10mls when she woke at approximately 5.30am and again at about 3.00pm in the afternoon. This does not appear to have been considered by anyone. My investigator was told by the Substance Misuse Development Manager that she was not aware of women being prescribed the extra 10mls, although staff should have been aware of the option. She explained that some women exaggerate their distress and ask for extra medication whether it is needed or not. The desire to avoid being misled appears to have resulted in staff failing to consider the option of an extra dose as often as it might be appropriate. It should also be noted that the staff who saw the woman did not describe her as acutely unwell; in comparison to other women they see at Styal.
72. It appears that the woman gave no impression that she would consider harming herself. She was serving a short sentence and agreed to work with CARATs staff throughout. Her only apparent concern concerned withdrawal from drugs. It is not possible, or appropriate, to say that an extra dosage of methadone would have prevented her taking her life. However, it is a possible that an extra dose of methadone might have alleviated her distress. Unfortunately this is speculation. Having conducted interviews with the other staff who manage prisoners on methadone prescriptions, there does appear to be some discrepancy between what they think is allowed and what the Substance Misuse Development Manager explained:

**The Head of Healthcare should ensure that staff who care for prisoners with methadone prescriptions are aware that additional doses can be administered if necessary.**

73. One response from the woman's family questioned why she did not receive Quinine prior to her death. The investigator raised this with the clinical reviewer who said:
- "My view is that prescriber really needs to indicate the timescale within the medication should dispensed and administered. If the question is that, should [the woman] have been given the medication at an earlier stage then I think one would say that yes as the general rule would need to be that medications prescribed to alleviate symptoms should be given as soon as possible."
74. However, the clinical reviewer also pointed out that he had not found strong evidence to support the effectiveness of Quinine to control withdrawal related symptoms. Given this, he stated:

“Now if the question is whether [the woman] experienced unnecessary discomfort due to any delay in the administration of the medication, then I think that given that the medication is of questionable efficacy then one would answer in the negative.”

## **Resuscitation**

75. Healthcare staff began resuscitation immediately upon arriving at the woman’s cell. The officer began CPR without a mask, for which he deserves credit. The prison doctor attended quickly and pronounced the woman dead within five minutes of her being found. The clinical reviewer wrote regarding the length of CPR:

“ ... no particular significance can or should be attached to the duration of the resuscitation as the evidence suggests that the woman’s life could not have been saved. “

76. Whilst conducting CPR some vomit went into the officer’s mouth and after the resuscitation attempt he left the prison to have his teeth cleaned. He also needed to have various tests undertaken due to the risks from the vomit. The officer told my investigator that he had to arrange the tests himself:

“my medical requirements for checking for tests and whatever else, because obviously we’re not allowed to know the medical history so you have to assume until cleared. That’s kind of fell by the wayside, that didn’t really happen. So I had to push for my own tests and go on justify them to my own doctor as well who asked why the prison wasn’t doing them and where was our protocol for it.”

77. He later told my investigator:

“But since I’ve come back I’ve spoke to some POA members, I’ve spoke to, ended up with the prison FLO who spoke to the governing governor. There’s a system in place now for issuing the masks so that everybody gets them and trained to use them properly. There is going to be a principal officer who’s a liaison, an instant liaison officer for the staff; you know, have you got all, is there anything you need, what do you need for tests, those kind of things.”

78. The Deputy Governor also spoke to my investigator about this issue. She explained that first aid staff are being trained to use masks which are being issued immediately. She explained that the use of masks will be included in the national heart start training for new officers.

79. I am encouraged to hear that the prison is treating the matter seriously and make no recommendation due to the work that has already begun. However, I encourage the Governor to ensure that the work is completed and procedures are in place should such a situation occur again.

80. One response from the woman's family praised the officer's conduct in attempting to resuscitate her, while another expressed scepticism that such an event occurred. All of the evidence reviewed and heard by the investigator corroborates the account provided by the officer and the investigator has no concerns regarding the veracity of his account.

### **Liaison with the woman's family**

81. The prison attempted to contact the woman's family as soon as possible after her death. Her partner was called by telephone as she had not provided an address for him. The PSO relating to deaths in custody strongly advises that the news is broken in person if at all possible. I understand that the woman's partner was of no fixed abode which made it difficult to meet him in person.
82. The carer of the woman's daughter was told by the police in the early hours of the morning. In these situations it is imperative that the family is told as soon as possible and I do not criticise the prison for deciding to involve the police.
83. The woman's family expressed their concern that she was allowed to have a belt and lanyard in her possession despite her vulnerability whilst withdrawing from drugs. The investigator was told by the prison that these types of items are only taken from prisoners deemed to be at risk of harming themselves. The woman never gave any indication that she would harm herself and I do not criticise the prison for their actions. There is a balance between safety and human decency, and in this case there was nothing to suggest that the decision should have come down on the side of safety.
84. The responses from the woman's family to the draft report again raised the issue of her having a belt in her possession. The report explains that such items are only taken away from prisoners when it is deemed that they are at high risk of harming themselves. This view was not held by staff that came into contact with her. PSO 2700 states:

“However, removing personal belongings from a person who is feeling hopeless and depressed ... can increase feelings of distress and therefore increase the risk of suicide, self-harm or a higher risk method of self-harm. Where possible, prisoners at risk should be allowed to retain their belongings unless it is clearly unsafe to do so.”

85. I understand that the prison contributed to the funeral costs and attended the service. I am also pleased to record that the woman's property was returned to her mother following the funeral.

### **Care for staff and prisoners**

86. The prison took the unusual step of telling other families who had lost loved ones at Styal of the woman's death. It was explained to my investigator that this was done to prevent them finding out through the media and potentially causing them more distress. I think this is a good example of the prison continuing to think of the needs of all the families involved.

87. I was interested to hear that the prison employs a full-time counsellor for the service of staff and their families. Several members of staff expressed to my investigator their appreciation of the support the counsellor offered them. I am pleased to highlight this area of good practice.

## **RECOMMENDATIONS**

1. The Governor should ensure sufficient training is carried out to enable all relevant members of staff to adequately understand the IEP policy.

The National Offender Management Service accepted this recommendation and said:

“The IEP Scheme has been the subject of a comprehensive review and the recommendations of the review have been accepted by the Governor. The policy will be amended and a comprehensive training awareness raising to improve understanding and compliance with policy.”

2. The Governor should ensure that decisions about loss of association for women suffering drug withdrawal are taken by the duty governor.

The National Offender Management Service accepted this recommendation and said:

“This is now embedded in the new IEP policy. All cases of women who may receive loss of association are scrutinised by the Duty Governor who makes the final decision.”

3. The Head of Healthcare should ensure that staff who care for prisoners with methadone prescriptions are aware that additional doses can be administered if necessary.

The National Offender Management Service accepted this recommendation and said:

“The Head of Healthcare is initiating an awareness programme for all directly employed Healthcare staff (and openly) to ensure they are aware of the additional dose that can be administered.”

## **GOOD PRACTICE**

4. The use of a counsellor for staff welfare is an example of good practice.