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BABY DEATH AT HMP STYAL – PPO REPORT HIGHLIGHTS SHOCKING CIRCUMSTANCES OF BABY STILLBORN IN PRISON

A woman prisoner gave birth to a still-born baby in shocking circumstances in a prison toilet, without specialist medical assistance or pain relief, an investigation by the Prisons and Probation Ombudsman (PPO) has found.

The 30-year-old mother did not know she was pregnant and did not believe she could be. The PPO investigation report found that fellow prisoners and staff had no suspicion that Ms B was pregnant before she gave birth in an emergency on the evening of 18 June 2020 at HMP&YOI Styal in Cheshire. Her roommate, a mother of four herself, only recognised possible signs that Ms B was pregnant in the hours before Ms B gave birth.

The Ombudsman said that she was satisfied that prison staff did not miss any obvious signs that Ms B was pregnant during her three and a half months at Styal, but that there were missed opportunities to identify that Ms B needed urgent clinical attention in the hours before she gave birth.

The woman, who was in prison for the first time, gave birth to a baby girl – possibly at the stage of 27-31 weeks of gestation – in the toilet of her houseblock. Sue McAllister, PPO, said the woman suffered a "terrifying, painful and traumatic experience" and her roommate and prison staff present were also profoundly affected. "Even at a distance this is a deeply sad and distressing case," Sue McAllister said.

The investigation found that a prison supervising officer (SO) made three calls to the duty nurse, raising concerns about Ms B, during a period of two hours from shortly before 7pm on 18 June. The nurse, without seeing Ms B and with inadequate reference to her medical file, concluded incorrectly that she was bleeding and suffering severe stomach pain as a result of a painful period. The nurse did not go to see Ms B.

Sue McAllister's report said: "We do not consider that (the nurse) should have concluded from the information provided by (the SO) that Ms B's situation was a maternity emergency. However, acute abdominal pain can have a variety of causes, some of which are very serious. We consider that the information provided by the SO was sufficient to have caused the nurse to visit Ms B, and that she should have done so.

"Regardless of the cause, it is not acceptable that anyone should be in unexplained acute pain for several hours without proper assessment or consideration of pain relief. Had proper triage taken place, Ms B might have given birth in hospital with proper clinical support and medication instead of in a prison toilet with untrained staff." All the other staff who tried to help Ms B and Baby B during and after the delivery acted with humanity and to the best of their abilities, the report added.

The Ombudsman said the PPO is not able to say whether the baby could have survived if Ms B had been taken to hospital earlier that evening. "We consider that this would need to be determined by a court on the basis of expert evidence commissioned for that purpose."

The PPO report says that there are a number of reasons why a woman in prison might not know she is pregnant or might deny pregnancy. It is important that prisons

do all they can to identify pregnant women and that trauma-informed care is at the heart of their approach.

More could be done to make pregnancy tests available and to explain the risks of not having one if there is any possibility the woman might be pregnant. The report recommends that women are offered a pregnancy test at both the initial and secondary health assessments after arriving at prison.

More could also be done during the secondary health assessment (which takes place a few days after arriving in prison when the woman has had a chance to adjust to her surroundings). The secondary health assessment should allow for discussion about sexual health, menstrual history and contraceptive history.

The report further recommends that nurses in women's prisons should have training in recognising early labour, and that all staff in women's prisons need to know what to do in the event of an unexpected birth.

The Prison Service and the NHS have accepted the Ombudsman's recommendations and produced an action plan setting out how they will be implemented.

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Notes to editors

- 1. The report is available on 11 January 2022 at www.ppo.gov.uk
- 2. Embargoed copies of the report and action plans are attached to this news release.
- 3. The Prisons and Probation Ombudsman (PPO) is appointed by and reports directly to the Secretary of State for Justice. The Ombudsman's office is wholly independent of the services in remit, which include those provided by Her Majesty's Prison and Probation Service (HMPPS), the National Probation Service for England and Wales, the Community Rehabilitation Companies for England and Wales, Prisoner Escort and Custody Service, the Home Office (Immigration Enforcement), the Youth Custody Service, and those local authorities with secure children's homes. It is also operationally independent of, but sponsored by, the Ministry of Justice (MoJ).
- 4. HMP Styal holds up to 486 women. There is a variety of residential units, with 16 separate houses each holding about 20 women, and a mother and baby unit. Spectrum Community Health runs healthcare services at the prison.
- 5. Read the PPO report, published in September 2020, on the death of a baby at HMP Bronzefield (link to main report here) https://s3-eu-west-2.amazonaws.com/ppo-prod-storage-1g9rkhjhkjmgw/uploads/2021/09/Prisons-and-Probation-Ombudsman-Bronzefield-Baby-A-Release.pdf

- 6. The roles and responsibilities of the PPO are set out in the Terms of Reference (ToR), the latest version of which can be found in the appendices.
- 7. The PPO has three main investigative duties:
 - complaints made by prisoners, young people in detention, offenders under probation supervision and individuals detained under immigration powers (detained individuals)
 - o deaths of prisoners, young people in detention, approved premises' residents and detained individuals due to any cause
 - using the PPO's discretionary powers, the investigation of deaths of recently released prisoners
- 8. Please contact john.steele@justice.gov.uk if you would like more information