Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Ms Nicola Birchall, a prisoner at HMP/YOI Styal, on 4 February 2018

A report by the Prisons and Probation Ombudsman

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OUR VISION

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

WHAT WE DO

WHAT WE VALUE

The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out independent investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

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

Ms Nicola Birchall died from multiple drug use with chronic obstructive pulmonary disease on 4 February 2018, two days after arriving at HMP Styal. She was 41 years old. I offer my condolences to Ms Birchall's family and friends.

Ms Birchall had abused both illicit and prescription drugs for several years. She had very poor physical and mental health. She was detoxing when she arrived at Styal and was prescribed medication for her withdrawal symptoms.

The clinical reviewer is satisfied that the healthcare Ms Birchall received at Styal was equivalent to that which she could have expected to receive in the community.

I am concerned, however, that although prison staff observe all new prisoners hourly during their first night in custody, there are no formal observations on those women who are detoxifying after this. I am also concerned that although healthcare staff visit the First Night Centre three times a day to issue medication, the Centre is staffed by prison officers who have no specialist training in the management of prisoners who are withdrawing from drugs.

Ms Birchall vomited a great deal during her time in the Centre, but prison staff considered that this was normal for prisoners who were withdrawing and did not seek medical advice. We cannot say whether the outcome might have been different for Ms Birchall if she had been reviewed by a healthcare professional.

I am also concerned that the officer who unlocked Ms Birchall on the morning of her death did not obtain a response from her, as she should have done. As a result, it was another hour before her cellmate realised, she was unresponsive. We cannot say whether the outcome might have been different for Ms Birchall if she had been found earlier.

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

Sue McAllister, CB
Prisons and Probation Ombudsman **September 2019**

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Summary

Events

1. On Friday 2 February 2018, Ms Nicola Birchall was remanded to HMP Styal after being arrested and charged with possession of class A drugs with intent to supply. Ms Birchall had been at Styal previously and was known to staff.

2. When she arrived at the prison, Ms Birchall was taken to the First Night Centre (FNC) and she was assessed by a healthcare assistant (HCA). The HCA recorded a detailed medical history. Following the initial health screen, a further assessment and more in-depth record of Ms Birchall's medical history was completed by a nursing practitioner.

3. Ms Birchall was identified as detoxing from illicit drugs and she was also in receipt of a regular methadone prescription. Medication to alleviate symptoms of withdrawal were prescribed and on Saturday 3 February, Ms Birchall was prescribed 70ml of methadone.

4. Ms Birchall vomited a great deal and spent much of her time sleeping, although she did leave her room at times to associate with other prisoners.

5. At 9.10am on Sunday 4 February 2018, an officer began to unlock the women on the FNC to collect their breakfast. At 10.10am, staff were alerted by a commotion upstairs. They immediately ran upstairs and found Ms Birchall lying unresponsive on her bed. An officer immediately used her radio to call a medical emergency code.

6. A nurse arrived and checked for a pulse but found none. More staff arrived and brought the emergency medical equipment, including a defibrillator. Staff began cardiopulmonary resuscitation (CPR) until an ambulance arrived at 10.20am.

7. Staff and paramedics continued resuscitation for 60 minutes but Ms Birchall did not respond to treatment. At 11.15 am, the paramedics confirmed that Ms Birchall had died.

8. The post-mortem report gave the cause of death as multiple drug use with chronic obstructive pulmonary disease.

Findings

9. The clinical reviewer is satisfied that the clinical care Ms Birchall received at Styal was equivalent to that which she could have expected to receive in the community. She said that Ms Birchall's physical and mental health concerns were identified and recorded appropriately and that she was prescribed appropriate medications, including methadone, for her drug withdrawal.

10. We are concerned that although prison staff observe all new prisoners hourly in the FNC during their first night in custody, there is no formal monitoring of those women who are detoxifying from drugs after this.

11. We are also concerned that apart from when nurses visit to give medication three times a day, there is no healthcare presence in the FNC and it is staffed by prison

officers who have no specialist training in the management of prisoners who are withdrawing from drugs.

12. When an officer unlocked Ms Birchall's room door on 4 February, she did not wait to get a response from Ms Birchall before moving onto the next room, which is contrary to Prison Service instructions. As a result, Ms Birchall was not found unresponsive until an hour later. We cannot say whether earlier intervention might have changed the outcome for Ms Birchall.

Recommendations

- The Governor and Head of Healthcare should review the presence of healthcare and substance misuse staff in the First Night Centre.
- The Governor should consider detoxification awareness training for all officers who work in the First Night Centre, to ensure safe and supportive management of prisoners withdrawing from drugs.
- The Head of Healthcare should ensure that prison staff in the FNC have written guidance on what symptoms they should watch for in detoxing prisoners and when they should seek medical help.
- The Governor should review the procedures for unlocking prisoners and ensure that, when a cell door is unlocked, staff satisfy themselves of the safety of the prisoner and that there are no immediate issues that need attention.

The Investigation Process

13. HMPPS notified us of Ms Birchall's death on 5 February 2018.

14. The investigator issued notices to staff and prisoners at HMP Styal informing them of the investigation and asking anyone with relevant information to contact him. No one responded.

15. The investigator obtained copies of relevant extracts from Ms Birchall's prison and medical records.

16. The investigator interviewed four members of staff at HMP Styal on 15 March 2018.

17. NHS England commissioned a review into Ms Birchall's clinical care at the prison. The reviewer attended all interviews.

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

19. The Coroner concluded an inquest on 29 July 2024 into Ms Birchall's death and concluded that her death was the result of long term and ongoing drug use, which included a severe respiratory disease.

20. The Ombudsman's family liaison officer contacted Ms Birchall's to explain the investigation and to ask if they had any matters, they wanted us to consider.

    - Ms Birchall had a badly infected leg prior to going into custody. Did she receive the appropriate treatment for this?
    - Did Ms Birchall press the cell bell to call for help on the morning of 4 February?
    - Was Ms Birchall checked during the night?
    - Did Ms Birchall receive appropriate treatment for her withdrawal, and could her death have been prevented?

Background Information

HMP Styal

21. HMP Styal is a female prison holding up to 460 women. There is a variety of residential units with 16 separate houses each holding about 20 women, and a mother and baby unit.

22. Spectrum Community Health provides healthcare services at the prison. Lifeline delivers psychosocial intervention to substance users. Greater Manchester West Mental Health NHS Foundation Trust provides mental health services. There are nurses on duty at all times, with one registered nurse and a health support worker available at night. GP sessions are held every day except Sundays, when there is an out of hours service. There is no in-patient facility.

HM Inspectorate of Prisons

23. HMP Styal is a female prison holding up to 460 women. There is a variety of residential units with 16 separate houses each holding about 20 women, and a mother and baby unit.

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Independent Monitoring Board

25. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report for the year to April 2018, the IMB reported that very appropriate care and support was given to new admissions through Reception and on to the First Night Centre, and that both units made good use of peer mentors in supporting the new admissions.

Previous deaths at HMP Styal

26. Ms Birchall's death was the third death at HMP Styal since August 2016. One of the previous deaths was self-inflicted and one was from natural causes. There were no significant similarities with Ms Birchall's death. There have been three apparently self-inflicted deaths since.

Key Events

27. On Friday 2 February 2018, Ms Nicola Birchall was remanded to HMP Styal after being arrested and charged with possession of class A drugs with intent to supply. Ms Birchall had been at Styal previously and was known to staff.

28. When she arrived at the prison, Ms Birchall was taken to the First Night Centre (FNC) where she had a reception screen and was assessed by a healthcare assistant (HCA). The HCA recorded a detailed medical history, recording that Ms Birchall had a twenty-year drug history and was an intravenous drug user. Ms Birchall said that she had been injecting drugs into her groin. The HCA took Ms Birchall's clinical observations of heart rate, blood pressure (which was raised at 131/96), and temperature, which was normal, and all indicative of withdrawal symptoms. She also examined Ms Birchall's groin area and recorded that there were no signs of infection.

29. Ms Birchall told the HCA that she did not have any thoughts of suicide or any intent to self-harm while in custody but said that she had made cuts to her arms prior to custody, although she did not indicate how long before. The HCA did not consider there was a need for Ms Birchall to be monitored under suicide and self-harm prevention procedures (known as ACCT).

30. A further assessment and more in-depth record of Ms Birchall's medical history was completed by a Nursing Practitioner. The nursing practitioner noted that Ms Birchall had a 20-year history of poly-drug use, intravenous heroin use and alcohol abuse. She also noted that Ms Birchall's physical health problems were extensive and included kidney, chest, circulatory and breathing problems associated with asthma and chronic obstructive pulmonary disease (a collection of lung diseases), epilepsy, cellulitis (an infection of the skin), abscesses and leg ulcers (from intravenous drug injection sites) and deep vein thrombosis. Ms Birchall's medical history recorded that she frequently refused to engage with mental health, physical health and substance misuse services, both in the community and during previous periods in prison.

31. Ms Birchall also had a history of poor mental health. She had been diagnosed with paranoid schizophrenia in 2011/2012, had a history of depression, and had been detained under the Mental Health Act in 2011.

32. The nursing practitioner prescribed methadone (for drug detoxification), mirtazapine (used to treat depression) and quetiapine (an antipsychotic drug used to treat paranoid schizophrenia).

33. Ms Birchall said that she regularly took 300mg of pregabalin, twice a day, in the community. (The clinical reviewer could find no record that Ms Birchall had been prescribed pregabalin.) Pregabalin is used for the treatment of epilepsy and anxiety and for pain relief. It is frequently abused because of its euphoric effects. The nursing practitioner told Ms Birchall that she would not be prescribed pregabalin as tradable and abused medications such as pregabalin are not prescribed under the prison's drug policy.

34. The nursing practitioner recorded that Ms Birchall had last used heroin and crack cocaine on 31 January. She identified that Ms Birchall was showing signs of

moderate levels of opiate withdrawal. Ms Birchall refused to comment when asked about her alcohol consumption. Her scores for alcohol withdrawal were zero. The nursing practitioner prescribed medication to alleviate the symptoms of opiate withdrawal and made a routine referral to the mental health team.

35. Ms Birchall was located in a shared room in the FNC. She was observed hourly during her first night. (All new prisoners are observed hourly on their first night, not just those detoxing.)

36. On the morning of 3 February, an HCA completed Ms Birchall's secondary health screen. The HCA repeated the assessment to gauge the level of opiate withdrawal and the results showed it had reduced.

37. A member of staff from the Chaplaincy noted that he had seen Ms Birchall that morning but that she "was too ill and out of things to talk to".

38. Later that day, a mental health nurse went to see Ms Birchall to complete a routine mental health assessment. Ms Birchall declined to engage with her because she said she was feeling unwell due to detoxing but said she would engage with the service when she was feeling better. The mental health nurse placed Ms Birchall on the list for discussion by the mental health team on 6 February.

39. That afternoon, the nursing practitioner prescribed 70ml of methadone after confirming Ms Birchall's prescription with the community pharmacy.

40. Ms Birchall's cellmate told the investigator that although Ms Birchall was clearly detoxing and unwell, she had left their room on Friday evening and Saturday morning to associate with the other women in the unit. The prisoner said that she did not see Ms Birchall use any illicit drugs at Styal.

41. An officer told the investigator that Ms Birchall appeared to be detoxing. She said she had vomited in the association room on Friday evening and Saturday morning and had spent much of the time sleeping since arriving in the FNC. The officer said that Ms Birchall was known to be detoxing and although she was unwell, this was not unusual when women were detoxing, and she had no other reason to alert healthcare staff about Ms Birchall's condition.

Events of 4 February 2018

42. The cellmate told the investigator that Ms Birchall had been in and out of sleep during the night and they were both awake at around 6.00am in the morning, then Ms Birchall went back to sleep. Ms Birchall did not ring her cell bell during the night or morning of 4 February.

43. At 9.10am, an officer began to unlock the women in the FNC for breakfast. The officer was not available for interview, but provided the investigator with a statement which said that when she unlocked Ms Birchall's room door, she looked in and Ms Birchall appeared to be asleep. The officer did not call out to Ms Birchall and wait for a response. She then unlocked the remainder of the rooms, before returning downstairs to the ground floor.

44. The officer said that based on her observation of Ms Birchall over the weekend, she did not think it was unusual for Ms Birchall to still be sleeping. Although, Ms Birchall

did not collect her breakfast on the Sunday morning, the officer said that she was satisfied she had seen Ms Birchall at unlock. There are no organised activities in the FNC Centre on a Sunday, so she did not feel it necessary to ensure that Ms Birchall was up and about, but decided to let her rest, as she had obviously not been very well over the weekend.

45. At 10.10am, the officer heard "a lot of commotion" upstairs, and somebody shouting and screaming. The officer and another officer immediately ran upstairs and found the cellmate in a hysterical state and shouting, 'She's dead.'

46. The officer saw Ms Birchall lying on her bed and radioed a code blue emergency (indicating that a prisoner is unconscious or having breathing difficulties). An ambulance was called immediately by staff in the control room.

47. A nurse responded. She saw Ms Birchall lying on the bed, facing away from her. When she turned Ms Birchall over she noted that her mouth and hands were blue and she had a pale complexion. There was also a bucket of vomit next to her bed. The nurse checked for a pulse but found none.

48. A custodial manager arrived, followed by an HCA who brought the emergency medical equipment, including a defibrillator. They started cardiopulmonary resuscitation (CPR). Another nurse also arrived. She assisted with CPR and helped to move Ms Birchall out of the room and onto the landing.

49. At interview staff said that Ms Birchall did not show signs of rigor mortis. She was warm to touch, although mottled and pale. She had cyanosed lips (low levels of oxygen) and blue hands.

50. Healthcare and custodial staff continued with CPR until paramedics arrived at 10.20am. Staff and paramedics continued resuscitation for 60 minutes. Ms Birchall did not respond to treatment and at 11.15am, the paramedics confirmed that Ms Birchall had died.

Contact with Ms Birchall's family.

51. Following Ms Birchall's death, the Governor visited Ms Birchall's family to inform them of her death. The family were told that an investigation would follow and they were offered continued support.

52. The prison contributed towards the cost of Ms Birchall's funeral in line with national policy.

Support for prisoners and staff

53. After Ms Birchall's death, the duty governor debriefed the staff involved in the emergency response, alongside the Governor to ensure they had the opportunity to discuss any issues arising, and to offer support.

54. The prison posted notices informing other prisoners of Ms Birchall's death and offering support. The residents were briefed in person regarding Ms Birchall's death, including a member of the Chaplaincy team to offer further support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Ms Birchall's death.

Post-mortem report

55. The toxicology tests found that several substances were present in Ms Birchall's system, including methadone, cocaine, free morphine, dihydrocodeine, quetiapine and quinine.

56. The pathologist found that the individual levels of drugs were an indication of heavy use prior to Ms Birchall being arrested on 2 February, and that drug interactions were complex and unpredictable.

57. The pathologist concluded that on the balance of probabilities, the effects of Ms Birchall's long-term drug use had a bearing on her death, due to her congested lungs. The pathologist gave the cause of death as multiple drug use with chronic obstructive pulmonary disease.

Findings

Clinical care

58. Ms Birchall had a very long history of poly-drug misuse, and often failed to engage with mental, physical and substance misuse services in the community, despite services attempting to engage with her. Thorough first and second reception screenings were completed by healthcare staff at Styal. Mental health services attempted to engage with Ms Birchall, but she declined.

59. The clinical reviewer is satisfied that the clinical care Ms Birchall received at Styal was of a good standard and equivalent to that which she could have expected to receive in the community.

60. The clinical reviewer considered that Ms Birchall's leg ulcers were due to her intravenous drug injecting. Her community medical records noted that she had frequently failed to attend appointments to have the ulcers treated and dressed.

61. It is unclear what condition the leg ulcers were in when she arrived at the prison as there is no evidence that Ms Birchall told staff that they were a problem or needed attention. The clinical reviewer said that Ms Birchall's clinical observations were all within acceptable limits for her age and indicated no signs of infection from the ulcers at that time. The pathologist recorded that Ms Birchall had " chronic ulceration to the lower left shin" and noted that, although "there was a small amount of surface pus staining, there did not appear to be a significant infection in the surrounding tissues".

Detoxification monitoring arrangements.

62. Ms Birchall was located in the FNC at Styal. All women entering the prison are expected to remain in the FNC for at least 48-72 hours, during which time they will be seen and interviewed by support services including the Drug and Alcohol Recovery Service (DARS) and the Chaplaincy. Nursing staff attend the FNC every morning, afternoon and evening to issue medications, but there is no healthcare or DARS presence on the unit outside of these times.

63. All prisoners in the FNC are observed by prison staff hourly during the first night in custody. This is routine and regardless of any concerns relating to underlying risk, such as detoxification. After the first night, there are no further requirements for staff to monitor prisoners, including those who are detoxing (unless they are subject to ACCT procedures).

64. The clinical reviewer found that the management of Ms Birchall's detoxification was reasonable. Healthcare staff appropriately identified that Ms Birchall was showing signs of drug withdrawal during her reception screen and prescribed the most appropriate medication in line with withdrawal guidelines. Opiate withdrawal drugs were prescribed in the appropriate timescales, and signs of alcohol and drug withdrawal were noted in her medical records, using the appropriate withdrawal scoring systems.

65. However, we are concerned that there is insufficient healthcare and DARS presence in the FNC to support and monitor women who are detoxing from drugs.

Although prison officers have no official substance misuse training, they are expected to contact healthcare staff or use the out of hours service if they have any concerns. We have not seen any guidance that tells them what concerning symptoms they should look for or when they should seek medical attention for a prisoner.

66. Ms Birchall had symptoms of opiate withdrawal on her arrival at the prison and she was prescribed methadone. It is clear that she was unwell and had been vomiting over the weekend. The officer said that she was aware that Ms Birchall was unwell due to withdrawal symptoms but that this was not unusual and that there was, therefore, no reason to alert healthcare staff to Ms Birchall's condition.

67. We are concerned that Ms Birchall was not formally monitored by healthcare staff while she was detoxing. There is no evidence that healthcare staff advised prison staff what to do if Ms Birchall continued to vomit for a prolonged period or if she showed any other symptoms.

68. We are also concerned that there is a lack of support for the prison officers in the FNC who are not medically trained or trained in the management of opiate substitute treatment but are expected to support those prisoners going through the detoxification process. Prison staff told the investigator that there is a team of staff who predominantly work in the FNC, but that any member of prison staff could be asked to work there. The FNC would benefit from having nursing staff more frequently available.

69. We cannot say whether the outcome might have been different for Ms Birchall if she had been reviewed by a healthcare professional.

70. We make the following recommendations:

- **The Governor and Head of Healthcare should review the presence of healthcare and substance misuse staff in the First Night Centre.**
- **The Governor should consider detoxification awareness training for all officers who work in the FNC, to ensure safe and supportive management of prisoners withdrawing from drugs.**
- **The Head of Healthcare should ensure that prison staff in the FNC have written guidance on what symptoms they should watch for in detoxing prisoners and when they should seek medical help.**

Unlocking procedures

71. The cellmate said that Ms Birchall was alive at around 6.00am on 4 February. Staff said that rigor mortis was not present when Ms Birchall was found unresponsive in her room at 10.10am. This suggests that she may have been alive or very recently dead when the officer unlocked her room at 9.10am.

72. On unlock procedures, Prison Service Instruction (PSI) 75/2011, Residential Services, says:

- 'Reports from the Prisons and Probation Ombudsman on deaths in custody have identified cases in which a prisoner has died overnight … but staff

unlocking them have not noticed that the prisoner had died. This is not acceptable ...

- '[Differing] arrangements will depend on the local regime, but there need to be clearly understood systems in place for staff to assure themselves of the wellbeing of prisoners during or shortly after unlock ... Where prisoners are not necessarily expected to leave their cell, staff will need to check on their well-being, for example by obtaining a response during the unlock process.'

73. The officer did not check the welfare of Ms Birchall when she unlocked her room, which is not in line with Prison Service instructions. As a result, Ms Birchall's condition went unnoticed until her cellmate was unable to rouse her an hour later. We cannot say whether earlier intervention might have changed the outcome for Ms Birchall.

74. We make the following recommendation:

- **The Governor of HMP Styal should review the procedures for unlocking prisoners and ensure that, when a cell door is unlocked, staff satisfy themselves of the safety of the prisoner and that there are no immediate issues that need attention.**

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