

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Ms Christine McDonald, a prisoner at HMP Styal, on 3 March 2019

A report by the Prisons and Probation Ombudsman

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



© Crown copyright, 2024

This report is licensed under the terms of the Open Government Licence v3.0. To view this licence, visit nationalarchives.gov.uk/doc/open-government-licence/version/3

Where we have identified any third-party copyright information you will need to obtain permission from the copyright holders concerned.

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.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Ms Christine McDonald died in hospital on 3 March 2019. She had been found hanging in her cell at HMP Styal the day before. Ms McDonald was 55 years old. I offer my condolences to her family and friends.

Ms McDonald was at Styal for just over 24 hours. She had several factors which increased her risk to herself when she arrived. I am concerned that staff did not sufficiently consider these risk factors.

Ms McDonald was withdrawing from drugs. This was not appropriately managed. She was not observed in line with policy, she was not appropriately assessed when she returned from hospital; and significant interactions with her were not always recorded.

I am also concerned that staff did not use the correct emergency code when they found Ms McDonald, resulting in a delay in calling the ambulance.

Ms McDonald is the third woman to die in the first night centre at Styal since February 2018. I have repeated our previous concerns that, apart from when nurses visited to give medication three times a day, there was no healthcare presence in the first night centre and it was staffed by prison officers who had no specialist training in the management of prisoners who are withdrawing from drugs. I have escalated these concerns to the Prison Group Director for women's prisons.

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

March 2020

Contents

Summary 1

The Investigation Process.....4

Background Information.....4

Key Events.....8

Findings8

Summary

Events

1. On 1 March 2019, Ms Christine McDonald was sentenced to 12 weeks imprisonment and taken to HMP Styal. She had witnessed her child falling from a third-floor window earlier that day and was concerned about her.
2. Ms McDonald told an officer and nurse that she was withdrawing from drugs. However, as she could not provide a urine sample, they were unable to prescribe her methadone. She said she had no thoughts of suicide or self-harm. She asked staff what had happened to her child.
3. The next day, Ms McDonald continued to suffer apparent withdrawal symptoms. She was still unable to provide a urine sample. Nurses were concerned about her symptoms and behaviour and continued high pulse rate. They arranged for her to be taken to hospital for assessment. Officers escorted Ms McDonald to hospital but she discharged herself and returned to the prison.
4. One of Ms McDonald's children telephoned the prison that evening and told the Orderly Officer that Ms McDonald's other child, who she had seen falling, had serious injuries but was stable. The Orderly Officer agreed to tell Ms McDonald but did not do so immediately as he had other duties.
5. At 10.30pm, an officer support grade (OSG) spoke to Ms McDonald in her cell. He said had no concerns about her. Other prisoners said that they heard Ms McDonald screaming that night and expressing concern about her child.
6. At 11.07pm, the Orderly Officer and the OSG went to Ms McDonald's cell to tell her that her child was stable. They found that Ms McDonald was hanging from her observation panel. They requested medical assistance and went into the cell. Nurses arrived within seconds and tried to resuscitate Ms McDonald. She was taken to hospital but died at 5.06pm the next day.

Findings

Assessment of risk

7. Ms McDonald had several risk factors for suicide and self-harm when she arrived at Styal. We are concerned that in assessing Ms McDonald's risk to herself, staff did not consider all these factors but relied on her assurances that she had no thoughts of harming herself.
8. We accept that the Orderly Officer had not been told that Ms McDonald was in distress. Nevertheless, we think he should have appreciated how anxious Ms McDonald be would naturally about her daughter and should either have prioritised telling her himself or should have asked someone else to tell her as soon as possible.

Clinical care

9. Ms McDonald's physical and substance misuse healthcare was not equivalent to that which she could have expected to receive in the community. Healthcare staff did not consider information from Ms McDonald's person escort record (PER). Nurses did not record all significant interactions they had with Ms McDonald. When Ms McDonald returned from hospital after discharging herself against medical advice, healthcare staff did not assess her. We are also concerned that healthcare staff did not monitor Ms McDonald's drug withdrawal symptoms appropriately.
10. Ms McDonald is one of three women to die in the first night centre at Styal since February 2018. We are concerned that, apart from when nurses visited to give medication three times a day, there was no healthcare presence in the first night centre and it was staffed by prison officers who had no specialist training in the management of prisoners who are withdrawing from drugs.

Emergency response

11. Staff did not use the appropriate emergency code when they found Ms McDonald hanging. While this, by chance, did not lead to a delay in nurses attending, it did lead to a delay in calling an ambulance. We found that staff were generally unclear about the emergency codes used at Styal.

Recommendations

- The Governor and Head of Healthcare should ensure that reception staff:
 - have a clear understanding of their responsibilities and the need to share all relevant information about risk;
 - do not rely solely on what a prisoner says or how they appear but consider and record all the known risk factors of a newly arrived prisoner when determining the risk of suicide and self-harm; and
 - open ACCT procedures when indicated.
- The Governor and Head of Healthcare should ensure that nurses conducting reception health screenings always have access to the PER.
- The Head of Healthcare should ensure that the clinical record is an accurate reflection of significant interactions between staff and prisoners.
- The Governor and Head of Healthcare should ensure that:
 - healthcare staff assess prisoners in reception when they return from hospital; and
 - there is effective written communication of clinical risks and health needs of prisoners returning from hospital and a formal discharge summary informs their care.
- The Governor and Head of Healthcare should ensure that all prisoners arriving with or developing signs of drug or alcohol withdrawal are regularly monitored, including clinical observations overnight and during the day, until they are stable.

- The Prison Group Director for women's prisons should write to the Ombudsman setting out what he has done to satisfy himself that there is sufficient healthcare presence in the first night centre; that prison staff working in the first night centre have been adequately trained in the management of prisoners withdrawing from drugs and alcohol; and that steps are being taken to ensure that staff do not become desensitised to residents' distress.
- The Governor should ensure that all prison staff are made aware of and understand their responsibilities during medical emergencies, in particular that staff efficiently communicate the nature of a medical emergency using the appropriate code.
- The Head of Healthcare should share this report with healthcare staff named in it and discuss its findings with them.
- The Governor should ensure that this report is shared with a CM and a OSG and that a senior manager discusses our findings with them.

The Investigation Process

12. The investigator issued notices to staff and prisoners at HMP Styal informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
13. The investigator visited Styal on 5 March. She obtained copies of relevant extracts from Ms McDonald's prison and medical records.
14. The investigator interviewed 16 members of staff and 4 prisoners at Styal in March and April.
15. NHS England commissioned a clinical reviewer to review Ms McDonald's clinical care at the prison. The clinical reviewer conducted joint interviews with the investigator.
16. We informed HM Coroner for Cheshire, Halton and Warrington of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
17. One of the Ombudsman's family liaison officers contacted Ms McDonald's next of kin, to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She asked:
 - Who assessed Ms McDonald when she arrived at Styal?
 - Was Ms McDonald prescribed methadone at Styal?
 - What happened when Ms McDonald was taken to hospital on 2 March? Was she told anything that heightened her risk to herself?
 - What physical healthcare did Ms McDonald receive when she returned to prison from hospital?
 - What was Ms McDonald's mood like on 2 March? Did she have contact with other prisoners?
 - Did she press her cell bell before the officer spoke to Ms McDonald at 10.30pm on 2 March? What did they talk about?
 - How did Ms McDonald take her own life?
 - Why did it take the custodial manager three hours to relay a message to Ms McDonald about her other child?
18. We have addressed these questions in this report.
19. Ms McDonald's family received a copy of the draft report. The solicitor representing Ms McDonald provided evidence of the time Ms McDonald's next of kin telephoned the prison. The report has been amended accordingly. They also raised a number of questions that do not impact on the factual accuracy of this report. We have provided clarification by way of separate correspondence to the solicitor.

20. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies and their action plan is annexed to this report.

Background Information

HMP Styal

21. HMP Styal holds up to 486 women. There are a variety of residential units, with 16 separate houses holding about 20 women, and a mother and baby unit.
22. Spectrum Community Health runs healthcare services at the prison. 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 inpatient facility.

HM Inspectorate of Prisons

23. The most recent inspection of HMP Styal was in May 2018. Inspectors reported that women were well cared for when they arrived at Styal and induction was thorough. Prisoners stayed on the first night centre for 48 hours before moving elsewhere in the prison. They found that the management of prisoners on ACCTs was good. The availability of illicit substances was high and over 50% of women said they had a drug problem on arrival. However, inspectors found that the supply reduction strategy was practical, well informed and focussed on supporting women, alongside preventative measures.
24. Inspectors found that new arrivals with substance misuse issues were promptly identified, received appropriate medication and were referred for psychosocial support. However, they found that during the first five days of drug detoxification, daytime monitoring was inconsistent and there was no routine night-time monitoring which created significant risks for those prisoners.

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 appropriate care and support was given to new prisoners in reception and the first night centre. They found that ACCT procedures were generally being used effectively.

Previous deaths at HMP Styal

26. Ms McDonald's death is the fifth death to occur at Styal since 2016. Two of these previous deaths were self-inflicted, one was due to natural causes and in one the cause of death was unascertained. There has been a further self-inflicted death since that of Ms McDonald. Three of these deaths have occurred in the first night centre.
27. Our previous investigations have raised issues about assessing a prisoner's risk to themselves, use of emergency codes and the presence of healthcare staff in the first night centre. It is troubling to be raising these issues once more.

Assessment, Care in Custody and Teamwork (ACCT)

28. ACCT is the care planning system the Prison Service uses to support prisoners at risk of suicide or self-harm. The purpose of the ACCT is to try to determine the level of risk posed, the steps that staff might take to reduce this and the extent to which staff need to monitor and supervise the prisoner. Checks should be made at irregular intervals to prevent the prisoner anticipating when they will occur. Part of the ACCT process involves assessing immediate needs and drawing up a caremap to identify the prisoner's most urgent issues and how they will be met. Staff should hold regular multidisciplinary reviews and should not close the ACCT plan until all the actions of the caremap are completed. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody)*.

Key Events

29. Ms Christine McDonald had previously served short sentences in prison, most recently in 2014. In 2014, Ms McDonald told a prison nurse that she had previously self-harmed and had taken an overdose four years ago. She also had thoughts of taking her own life and was subject to Prison Service suicide and self-harm prevention procedures, known as ACCT, for a short time. She was treated for depression by her GP in the community. In 2018, Ms McDonald was referred to the community mental health team but did not attend appointments and was discharged from the service.

1 March 2019

30. On 1 March 2019, Ms McDonald was arrested and sentenced to 12 weeks imprisonment for an offence of shoplifting and taken to HMP Styal. When she was arrested she was with one of her children who had tried to escape through a third-floor window and fallen to the ground. Ms McDonald had witnessed this and had seen her child being treated by ambulance staff before she was taken away by the police.
31. Ms McDonald arrived at Styal at 6.30pm. An officer interviewed her in reception. Ms McDonald declined a telephone call as she said she did not have any telephone numbers with her. She told the officer that she had no current or previous thoughts of suicide or self-harm. The officer noted that Ms McDonald seemed “quite tired” and was detoxing from drugs. She recorded that Ms McDonald was concerned about her child, as she did not know what had happened to her. The officer telephoned the local hospital, but Ms McDonald’s child had not been admitted there.
32. At 7.35pm, Ms McDonald moved to the first night centre. Her person escort record noted no risks of suicide or self-harm. At 8.50pm, a nurse assessed Ms McDonald. She told the nurse that she used heroin and amphetamines in the community. The nurse noted that Ms McDonald was anxious, irritable and appeared tired. She scored 13 on the clinical opiate withdrawal scale (COWS) which indicated that she was suffering from moderate withdrawal symptoms. Ms McDonald’s pulse was abnormally high, at 130 beats per minute. The nurse was concerned about this and told the investigator that she asked night staff to check this again. Ms McDonald told the nurse that she had no history of attempting suicide or self-harm. The nurse told the investigator that she had no concerns Ms McDonald was a risk to herself.
33. Ms McDonald was unable to provide a urine sample. As a result, the nurse could not prescribe methadone in line with Ms McDonald’s wishes. (Both national and local policy require that a prisoner must test positive for opiates before being prescribed methadone, otherwise there is a risk of opiate overdose.) The nurse prescribed symptomatic relief: ibuprofen, loperamide (to counteract diarrhoea), mebeverine (to counteract gut spasms), metoclopramide (to lessen nausea), paracetamol and quinine sulphate (to lessen muscle cramps).
34. An officer saw Ms McDonald shortly afterwards in her cell. The officer said that Ms McDonald was not happy that she could not provide a sample and therefore get the medication that she wanted. The officer told the investigator that she thought Ms McDonald had symptoms of drug withdrawal. Ms McDonald told the officer that she

was worried about her child and staff tried, unsuccessfully, to find out which hospital she had been taken to.

35. Later that evening, Ms McDonald told an officer that she was concerned about her child. She said she had no thoughts of suicide or self-harm. During the medication rounds, the officer went to Ms McDonald's cell and asked if she had been prescribed any medication. She said that Ms McDonald was making sounds as if she was in significant pain, groaning and clutching her stomach. Ms McDonald said she could not get downstairs to get any pain relief (where the nurse was located.) The officer therefore asked the nurse to go to Ms McDonald's cell and assess her when she had finished giving other prisoners their medication.
36. A nurse went to see Ms McDonald. She told the clinical reviewer that she took Ms McDonald's clinical observations, including blood pressure, heart rate, temperature, assessed her using the COWS tool and asked Ms McDonald about her withdrawal symptoms. She said Ms McDonald told her that she had stomach ache and was still unable to provide a urine sample. She did not record this information but the officer also recalled her assessing Ms McDonald. The only entry from the nurse in the medical record is at 11.59pm when she gave Ms McDonald her prescribed medication to assist in alleviating her withdrawal symptoms.
37. An Officer Support Grade (OSG) observed Ms McDonald hourly between 9.00pm and 7.00am, as was standard with all prisoners on their first night. He said that Ms McDonald was either awake and talking to her cellmate or asleep. The OSG told the investigator that he had no concerns about Ms McDonald.
38. Prisoners told the investigator that Ms McDonald was suffering severe withdrawal symptoms when she arrived at Styal. They said that Ms McDonald could not drink water because she was too nauseous and was concerned she could not provide a urine sample. Prisoners said that she had hot and cold sweats, stomach ache, aching legs and was vomiting. They tried to assist her by taking it in turns to sit with her, talk to her, reassure her and make her cups of tea. Prisoners said that Ms McDonald was also very concerned about her child's welfare. One prisoner told the investigator that Ms McDonald had told her, "I don't feel like living."
39. Ms McDonald's shared a cell. Her cellmate said that Ms McDonald managed to eat a little food and drank tea. She also tried to comfort and assist Ms McDonald. Some prisoners said that after she was locked in her cell, Ms McDonald banged on her cell door until the early hours of the following morning, shouting that she needed her medication. Prisoners also said that she pressed her cell bell. (No electronic records of cell bells are kept at Styal.) They said that staff responded by telling Ms McDonald that they could not give her methadone and that she should go to sleep.

2 March

40. On 2 March, a member of the chaplaincy team spoke to Ms McDonald in the morning. She told them that she was concerned about her child. They said they would contact the local hospital to try and find out details of her child's condition.
41. Her cellmate said that Ms McDonald did not want to speak other people that morning because of her withdrawal symptoms. She said they made some toast and ate breakfast together but that Ms McDonald seemed "really weak".

42. At 11.10am, a nurse assessed Ms McDonald for her secondary healthscreen. The nurse told the investigator that Ms McDonald came into her office wearing her coat even though it was not very cold. Her heart rate and blood pressure were both very high. She noted that Ms McDonald appeared “quite lethargic”. Ms McDonald was still unable to provide a urine sample. She noted that Ms McDonald appeared to become increasingly confused and disoriented during their assessment. The nurse took Ms McDonald up to her cell and helped her into bed, as she was unsteady. Her skin indicated that she was dehydrated. The nurse encouraged Ms McDonald to drink two glasses of water.
43. The nurse told the investigator that Ms McDonald returned to the office about 30 minutes later, presenting very differently, more alert, less unsteady and said she wanted to provide a urine sample. She was then unable to do so and again became unsteady. She told the investigator that Ms McDonald did not complain of any withdrawal symptoms from drugs.
44. The nurse said that she was concerned that there was “something not right” and spoke to another nurse for a second opinion. Both nurses went to see Ms McDonald. A nurse told the investigator that Ms McDonald’s presentation fluctuated between lethargic and unsteady with slurred speech, to more alert. The nurse did not think that the symptoms were typical of a prisoner withdrawing from drugs or who had used illicit drugs.
45. Since Ms McDonald’s pulse remained high, the nurses decided to do an ECG (electrocardiogram – to check the heart’s electrical activity). The service which interprets prisoners’ ECGs was unable to do so due to Ms McDonald’s high heart rate and advised that Ms McDonald needed to go to hospital for assessment (since there was no doctor in the prison as it was the weekend). They confirmed that she could go by taxi rather than ambulance.
46. All new prisoners at Styal have a mental health assessment within 24 hours of arriving. At 12.30pm, a nurse wrote up her notes from assessing Ms McDonald that morning. The nurse had seen Ms McDonald in her cell since she had told her that she was withdrawing from drugs and wanted to stay in bed. The nurse said that she did not witness any physical withdrawal symptoms herself. Ms McDonald said that she suffered from low mood but had not sought assistance with this in the past. She said she did not like using drugs or the associated lifestyle and she thought drugs would kill her. She said she had no current or past thoughts of suicide. She said she was worried about her child who she thought would be going to prison in the next few days. She said she wanted to engage with the mental health team. The nurse noted that she would refer her to a Psychology Wellbeing Practitioner to speak about her low mood.
47. Two officers escorted Ms McDonald to hospital. A nurse gave an officer a letter outlining her concerns about Ms McDonald to give to hospital staff. She also outlined her concerns to the officers. An officer told police that Ms McDonald was unsteady and said she was struggling to breathe. Ms McDonald was handcuffed by a single handcuff to an officer and, at 1.00pm, they left the prison in a taxi.
48. An officer told police that Ms McDonald was “agitated” and appeared as though she was withdrawing from drugs. He said that she was jerking her legs and “hunching over as though she had stomach pain”. An officer told police that she seemed to be

“in serious distress”, was shaking, in pain and could not stay still. While waiting to be assessed at the hospital, Ms McDonald told the officers that she had been in hospital a few weeks before due to heart problems.

49. At 2.15pm, escorting staff noted that hospital staff said Ms McDonald’s blood pressure was normal but her pulse was high. She needed to have a blood test but she became fidgety while waiting for this to happen and repeatedly asked staff to take her back to Styal. The officers tried to persuade her that it was in her best interests to stay at the hospital to be properly assessed. At 3.00pm, escorting staff noted that hospital staff said Ms McDonald’s ECG was high. The officers had also disclosed Ms McDonald’s recent hospital stay to medical staff. At 3.15pm, Ms McDonald discharged herself from hospital against medical advice. As she left the hospital, an officer said that she told the nurses that she could get methadone at prison. On the way back to the prison, an officer told the police that she continued to be in distress.
50. At 4.35pm, Ms McDonald’s cellmate was taken to hospital. Ms McDonald returned to the prison at 5.30pm. A nurse received a document with her abnormal ECG but did not see Ms McDonald herself. The nurse recorded this in her medical record along with a note that staff should obtain her heart rate later. The nurse did not receive Ms McDonald’s hospital discharge summary. Despite requests, the investigator has also not been able to obtain a copy. An officer said that the nurse asked him to take Ms McDonald to her office, which he did and handed her over to nursing staff there. No nurses the investigator spoke to said they had seen Ms McDonald on her reception to the prison.
51. An officer unlocked Ms McDonald for her medication at 7.45pm. She had a urine sample in a cup. A nurse was issuing medication that evening and explained she could not accept the urine sample as Ms McDonald had to provide the sample in a nurse’s presence to prove it was her own. Ms McDonald was unhappy about this and left the medication hatch without taking any of her other medication. The nurse told the investigator that Ms McDonald seemed “fine” and she had told her that if she felt unwell to let staff know. The nurse sent an electronic message to healthcare administration for them to make an appointment for Ms McDonald with a GP or Advanced Nurse Practitioner (ANP).
52. Ms McDonald returned to her cell - which she was in on her own as her cellmate had not returned – and an officer locked her in. Ms McDonald started banging her observation flap around five minutes later, so the officer returned upstairs and Ms McDonald told her she was annoyed that healthcare staff had not accepted her sample. The officer reiterated the reasons why, spoke to her for a few minutes and then left the cell. She said had no concerns that Ms McDonald was a risk to herself and she did not observe that Ms McDonald was suffering from any physical withdrawal symptoms.
53. The nurse told the investigator that before she finished her shift at 9.00pm, she gave a handover to the night healthcare staff that Ms McDonald had been to hospital, had a high heart rate and had self-discharged. She asked the nurses to monitor Ms McDonald and expected they would go and see her. A Healthcare Assistant told the investigator that she was aware that Ms McDonald had been out to hospital but said that no concerns were passed to her.

54. An Officer Support Grade (OSG) started working in the first night centre at 8.15pm that evening. He visited all prisoners on the unit. When he got to Ms McDonald's cell, he said that the observation panel was shut and locked, as it should have been. He said Ms McDonald was sitting in bed, with the light on in the cell. He told the investigator that he asked how she was and she replied, "Fine, thank you boss." The OSG said that he had no concerns about her and she seemed "friendly" and "content".
55. A Custodial Manager (CM) was the Orderly Officer in charge of the prison that night. During his handover, another CM told him that Ms McDonald had been to hospital and had an irregular heartbeat but had discharged herself from hospital. He said he passed this information on to the OSG. When asked by the investigator, the OSG did not recall this handover.
56. One of Ms McDonald's children telephoned the prison at 8.26pm and spoke to a CM. (The CM thought it was later than this but the investigator has since received Ms McDonald's next of kin telephone records confirming the time of the call.) She said that Ms McDonald's other child who had fallen from the window was stable but had injuries to her back, shoulder and pelvis. The CM told Ms McDonald's next of kin that he could not confirm whether Ms McDonald was at the prison but that if she was, he would pass on the news and would ask Ms McDonald to call her back tomorrow.
57. At 8.40pm, an officer heard banging coming from the cells upstairs (where Ms McDonald was located). She went upstairs and spoke to Ms McDonald whose observation panel was open. CCTV shows the panel had been opened a few seconds earlier. (The police have since found that the panel was faulty and, although appearing locked, could still be opened from the inside.) The officer told the investigator that Ms McDonald said she was "fine" when she asked how she was, and that she had no concerns about her.
58. A CM went to the first night centre at 9.50pm where he spoke with the OSG. He intended to pass on the message he had received for Ms McDonald but said he was then called away to check the key safe which took around 20 minutes and was an urgent task.
59. The OSG returned to Ms McDonald's corridor around 10.30pm, as it was a stormy night and he heard things rattling. He saw that Ms McDonald's light was on and spoke to her through the viewing window. He told the investigator that she was sitting up in bed and he asked her, "Are you okay? Aren't you tired?" and that she replied, "Alright boss, thank you". The observation panel remained closed. The OSG said he suggested that Ms McDonald have a cup of tea and watch some television. CCTV shows that he spoke to Ms McDonald for around one minute.
60. A prisoner in a neighbouring cell, said that Ms McDonald was suffering severe withdrawal symptoms that evening. She said she kept screaming and she assumed Ms McDonald was pressing her cell bell as an officer kept coming to talk to her. She said she heard the officer who responded tell her to "have a cup of tea and get her head down". She said that the officer was dismissive of her symptoms. She said shortly after the officer had gone, Ms McDonald shouted that she was going to kill herself. She said shortly after this Ms McDonald stopped banging on her cell door and shouting.

61. A prisoner also thought that the OSG was a bit abrupt but said that in general staff were trying to support Ms McDonald. She said she heard Ms McDonald shout that she was going to kill herself as she could not cope anymore, did not know where her child was, felt helpless and would be better off dead. She shouted to her to try to reassure her.
62. A CM returned to the first night centre at around 10.35pm. The OSG told him that he had just spoken to Ms McDonald and had no concerns about her. At 10.38pm, CCTV shows Ms McDonald's observation panel opening and her arm can be seen coming out through the panel. The panel remained open from this point.
63. The CM asked the OSG when he would next be checking prisoners, as he did not want to disturb them further. He said he would be doing so at 11.00pm and The CM said he would accompany him as he had some news for Ms McDonald. He told the investigator that he would have gone to see Ms McDonald straight away if he had thought that she was distressed. The CM and the OSG went to Ms McDonald's cell at 11.07pm (according to CCTV). The OSG noticed that the observation panel was open which he thought was strange as he had not opened the hatch when he last spoke to Ms McDonald.
64. The CM looked into Ms McDonald's cell through the observation panel. He thought Ms McDonald was sitting behind the door. He told her about her daughter's condition but she did not reply and he said to the OSG, "Something's not right." He then looked into the cell more carefully and noticed there was a ligature (a pair of leggings) tied around Ms McDonald's neck and secured to the observation panel. He had not noticed this initially as the leggings were the same colour as the observation panel.
65. The CM cut the ligature using his anti-ligature knife. He told the OSG to get prison and healthcare staff. The OSG radioed for healthcare staff to attend the first night centre. The CM unlocked the door and, after some difficulty getting into the room, as Ms McDonald was slumped against the door, both staff went in. CCTV shows this was around two and a half minutes after they first got to the cell. The CM laid Ms McDonald flat on the floor and checked for signs of life.
66. A nurse and a healthcare assistant were together on their way to another part of the prison when they received the OSG's message to go to the first night centre. They went there first, by chance, as it was closer than where they had been heading. When they got to the cell (20 seconds after the officers had gone in) and realised the nature of the emergency, the nurse told the healthcare assistant to get the emergency equipment from the office. The nurse checked for signs of life and they moved Ms McDonald to the corridor where there was more room. The nurse asked staff to request an ambulance and get a defibrillator. She started chest compressions. The OSG radioed for an ambulance to be requested. Staff in the communications room immediately telephoned an ambulance. The healthcare assistant went to get the defibrillator. Other staff arrived to assist.
67. The healthcare assistant returned to the cell with the emergency equipment. Nurses inserted an airway and administered oxygen while officers continued chest compressions. They attached the defibrillator and followed its instructions. Paramedics got to Ms McDonald's cell at 11.27pm and took over her care. They obtained a pulse and blood pressure.

3 March

68. On 3 March, at 12.10am, paramedics took Ms McDonald to hospital in an ambulance. She was admitted in a critical condition. At 2.00am, an officer, one of the escorting staff, noted that hospital staff had asked that Ms McDonald's next of kin be informed of her condition. She informed the CM.
69. At 2.10am, the CM telephoned Ms McDonald's child whom he had spoken to earlier but there was no reply. At 7.00am, staff contacted the police trying to find out which hospital Ms McDonald's other child was in. At 8.40am, staff obtained a number for another of Ms McDonald's children and telephoned her but there was no reply. At 10.15am, staff spoke to Ms McDonald's next of kin but the telephone line was unclear and she said she would call back. The Duty Governor, and a CM went to her home address, broke the news of her mother's condition and took her to the hospital. At 1.40pm, Ms McDonald's other children and sister arrived at the hospital. Ms McDonald died at 5.06pm, with her family present.

Support for prisoners and staff

70. After Ms McDonald's death, the Duty Governor, debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.
71. During the debrief, the OSG said that Ms McDonald had asked to see a nurse that night and he had said he would contact the nurse and ask her to come over when she was free. When asked about this, the OSG told the investigator that he could not remember Ms McDonald asking to see a nurse but that he did not contact one as he would have waited to speak to them when they came to the first night centre to administer medication between 10.30pm and 11.00pm.
72. Most staff felt well supported following Ms McDonald's death, except for a CM who would have liked more support from the senior management team.
73. Staff personally told prisoners in the first night centre that Ms McDonald had died. Prisoners said they had felt well supported. The prison also posted notices informing other prisoners of Ms McDonald's death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Ms McDonald's death.

Post-mortem report

74. The post-mortem examination concluded that Ms McDonald died due to hypoxic ischaemic brain injury (caused by a lack of oxygen to the brain), which was caused by a cardiac arrest as a result of Ms McDonald hanging herself.
75. Toxicology results showed evidence of amphetamine and heroin use. The pathologist said that, while this may have influenced her mental state, it did not directly contribute to Ms McDonald's death.

Findings

Assessment of risk

76. Prison Service Instruction (PSI) 64/2011, *Safer Custody*, which governs ACCT suicide and self-harm prevention procedures, requires all staff who have contact with prisoners to be aware of the risk factors and triggers that might increase the risk of suicide and self-harm and take appropriate action. Any prisoner identified as being at risk of suicide or self-harm must be managed under ACCT procedures. We have considered whether staff at Styal should have recognised Ms McDonald as being at risk and begun ACCT procedures to support her.
77. Ms McDonald had some risk factors for suicide and self-harm when she arrived at Styal. She had a history of mental health issues, said she suffered from low mood, had a history of drug misuse and was currently withdrawing from drugs. In 2014, she had taken an overdose and considered suicide and self-harm.
78. We recognise that many women arrive at Styal with similar risk factors and that it is not necessary or desirable to manage them all under the ACCT process. However, Ms McDonald had an additional significant risk factor: she was very concerned about the welfare of her child who she had seen fall out of a third-floor window. This was, not surprisingly a significant issue for Ms McDonald. She asked staff about her child in reception and again when she arrived in the first night centre, and she raised her concerns again the following morning with a chaplain and with a nurse. She also shared her concerns about her child with other prisoners. We are concerned that staff paid insufficient attention to this.
79. Staff judgement is fundamental to suicide and self-harm prevention, and relies on their using their experience and skills, as well as local and national assessment tools, to determine risk. We are concerned that in assessing Ms McDonald's risk to herself, staff did not consider all the risk factors involved but relied on Ms McDonald's assurances that she had no thoughts of this nature. Although we cannot say that staff should definitely have begun ACCT procedures, this was a finely balanced decision that should have taken account of all the risk factors, including her concerns about her child. We have not seen any evidence that this occurred. We make the following recommendation:

The Governor and Head of Healthcare should ensure that reception staff:

- **have a clear understanding of their responsibilities and the need to share all relevant information about risk;**
- **do not rely solely on what a prisoner says or how they appear but consider and record all the known risk factors of a newly arrived prisoner when determining the risk of suicide and self-harm; and**
- **open ACCT procedures when indicated.**

Clinical care

80. The clinical reviewer concluded that the decision not to prescribe methadone was in line with both national substance misuse guidance and local policy with one exception: that if a specialist substance misuse doctor had been available when Ms McDonald had arrived they may have prescribed a low dose of methadone based on their clinical judgement. In the circumstances, the decision not to prescribe methadone was the safest decision.
81. However, the clinical reviewer found that other aspects of Ms McDonald's physical and substance misuse healthcare were not equivalent to what she could have expected to receive in the community.
82. Nurses told the investigator that when they assess a prisoner arriving at Styal they do not have access to their PER. This contains vital information about a prisoner's risk to themselves and others, along with healthcare and substance misuse issues. The Head of Healthcare said that she would expect staff to have access to this information. We make the following recommendation:

The Governor and Head of Healthcare should ensure that nurses conducting reception health screenings always have access to the PER.

83. We are concerned that some significant interactions between healthcare staff and Ms McDonald were not appropriately recorded. When a nurse assessed Ms McDonald on the evening of 1 March following staff concerns, she did not document the observations that she took, only that she had given Ms McDonald her prescribed medication. When the nurse was unable to accept Ms McDonald's urine sample on 2 March, Ms McDonald left without taking her prescribed medication. This incident was not adequately documented. We make the following recommendation:

The Head of Healthcare should ensure that the clinical record is an accurate reflection of significant interactions between staff and prisoners.

84. A nurse told the investigator that when a prisoner returns from hospital, healthcare staff should assess them. The nurse said that rarely happened as nurses were often unaware they had returned. However, the officers who escorted Ms McDonald back from hospital said that they spoke to the nurse on their return. Despite this, no one assessed Ms McDonald when she returned to the prison. This was a missed opportunity to assess Ms McDonald's overall health, withdrawal symptoms and mood, particularly as she had discharged herself from hospital with a raised heart rate against medical advice. We make the following recommendation:

The Governor and Head of Healthcare should ensure that:

- **healthcare staff assess prisoners in reception when they return from hospital; and**
- **there is effective written communication of clinical risks and health needs of prisoners returning from hospital and a formal discharge summary informs their care.**

85. We are also concerned that Ms McDonald was not adequately monitored for her withdrawal from drugs. Apart from her initial and secondary healthcare screening on 1 March and 2 March, there were no healthcare observations or assessments noted in her clinical record. The nurse did assess her on the evening of 1 March when an officer expressed concerns about her, but she did not record this assessment. Several staff either recorded that Ms McDonald's heart rate should be taken (as it was abnormally high) or told the investigator that they asked or expected other staff to do this. This did not happen.
86. The healthcare provider's substance misuse policy refers to the need for regular observations overnight for women arriving in possible drug or alcohol withdrawal. This was not understood by some nurses and did not happen for Ms McDonald. The substance misuse manager said that two sets of observations should have been done overnight at 11.00pm and 3.00am. The clinical reviewer concluded that Ms McDonald's observations and general physical presentation should have been monitored overnight on 1 March with a view to considering whether she should be transferred to hospital.
87. HMIP identified concerns about inconsistent daytime and night-time monitoring for prisoners withdrawing from drugs in June 2018. It is therefore troubling that no progress seems to have been made in a year to reduce the risk created by this gap in service provision. We make the following recommendation:
- The Governor and Head of Healthcare should ensure that all prisoners arriving with or developing signs of drug or alcohol withdrawal are regularly monitored, including clinical observations overnight and during the day, until they are stable.**
88. During the staff debrief after Ms McDonald had been taken to hospital, the OSG said that Ms McDonald had asked to see a nurse that evening and that he had told her he would contact the nurse and ask her to come over. When asked about this by the investigator, he said that he could not remember Ms McDonald asking to see a nurse but said that if it was urgent he would have asked for a nurse to assess her immediately. Otherwise he said he would have waited until a nurse came to the wing to dispense medication later that evening.
89. We think it is most likely that Ms McDonald did ask for a nurse that evening since the OSG mentioned it at the debrief held shortly after her death. We would have expected the OSG to have made a record of Ms McDonald's request and we would also have expected him to contact healthcare and tell them about the request. It would then have been for nurse, and not the OSG, to say whether Ms McDonald needed to be seen immediately or whether the request could wait. We are concerned that the OSG took no action.
90. We also note that there is a significant difference between the OSG's account that Ms McDonald was "content" and told him that she was fine, and the accounts of other prisoners that she was screaming and banging her cell door and expressing concern about her child.
91. Following the death of a prisoner who was detoxing in the first night centre in February 2018, we recommended that the Governor and Head of Healthcare should review the presence of healthcare staff and substance misuse staff in the first night

centre. We also recommended that prison officers working in the centre receive detoxification awareness training and guidance on symptoms to be alert to in detoxing prisoners and when they should seek medical help.

92. The prison accepted these recommendations. We were told that the Head of Healthcare was reviewing and actioning healthcare staffing levels in the first night centre with a target date for completion of December 2019. We were also told that staff training would be arranged and that there would be a core group of staff in the first night centre who would take a consistent approach to detoxification issues, and that healthcare would produce an information sheet and guidance for prison staff that would be displayed in the first night centre.
93. Since then, there have been two further deaths in the first night centre (including Ms McDonald's) while prisoners were detoxing.
94. We remain concerned that, at the time of Ms McDonald's death, apart from when nurses visited to give medication three times a day, there was no healthcare presence in the FNC and it was staffed by prison officers.
95. We are also concerned that prison staff working in the first night centre may become desensitised to prisoners shouting and screaming as a result of drug detoxification and may come to regard this as normal behaviour and, in the absence of advice from healthcare staff, this may lead them to miss other possible causes of distress (such as Ms McDonald's concern about her child).
96. For these reasons, consider that, at the time of Ms McDonald's death, the first night centre was a potentially unsafe environment for prisoners who are detoxing. We recommend:

The Prison Group Director for women's prisons should write to the Ombudsman setting out what he has done to satisfy himself that there is sufficient healthcare presence in the first night centre; that prison staff working in the first night centre have been adequately trained in the management of prisoners withdrawing from drugs and alcohol; and that steps are being taken to ensure that staff do not become desensitised to residents' distress.

Telephone call from Ms McDonald's Next of Kin

97. Ms McDonald's next of kin rang the prison at 8.26pm and told a CM about her other child's condition. Since issuing our initial report, the timing of this call has been verified by Ms McDonald's child's telephone records. The CM had thought that he received the telephone call at approximately 9.25pm although he acknowledged it may have been "a little bit earlier" than this. Ms McDonald's next of kin told the PPO's family liaison officer that she told the CM that her mother would be "freaking out" not knowing what had happened to her sibling.
98. CCTV shows Ms McDonald's arm coming out through her observation panel at 10.38pm and it seems likely that this is the point at which she tied the ligature. The CM went to her cell to tell her that her child was stable at 11.07pm, by which time Ms McDonald had hanged herself. We do not know what led Ms McDonald to decide to take her life but it seems likely that worry about her child would have

played a part. We, have, therefore, considered whether the CM should have passed on the message about her child's condition sooner.

99. The CM told the investigator that he prioritised relaying the message from Ms McDonald's child to her. He wanted to see Ms McDonald personally as soon as possible. He initially went to the first night centre to relay the message to Ms McDonald at 9.50pm (which was nearly an hour and a half after the telephone call had taken place) but then got called away to another area of the prison. He returned around 10.35pm to relay the message but waited until 11.07pm to tell Ms McDonald (which was two hours and forty minutes after the telephone call).
100. We cannot say whether the news that her child was in a serious but stable condition would have prevented Ms McDonald using a ligature. However, if the CM had gone to give Ms McDonald the news sooner when he visited the first night centre for the second time, she would have been found sooner and her chances of being resuscitated successfully would have been higher (although by no means certain).
101. We recognise that as Orderly Officer, in charge of the prison overnight, the CM would have had many duties and responsibilities. Although he acknowledged that Ms McDonald's next of kin was anxious about her when he spoke to her, he had not been told of any issues with Ms McDonald and could not have been expected to know the extent of her distress that evening. When he returned to the first night centre for the second time, the OSG told him that he had just seen Ms McDonald and that he had no concerns about her.
102. We accept that the CM would have gone to speak to Ms McDonald more quickly if he had been told she was in distress. However, it should have been obvious that Ms McDonald would be very anxious about her child and we consider that he should have given greater priority to telling her or should have asked the OSG or another member of staff to pass the news to her when he realised he would not be able to do so quickly himself.

Emergency response

103. Prison Service Instruction (PSI) 03/2013, *Medical emergency response codes*, says that the Governor must have a medical emergency response code protocol that ensures that an ambulance is called automatically in a life-threatening medical emergency. The protocol gives guidance on efficiently communicating the nature of a medical emergency, ensuring that staff take the correct equipment to the incident and that there are no delays in calling an ambulance. It explicitly states that all prison staff must be made aware of, and understand, the protocol and their responsibilities during medical emergencies.
104. Governors are required to have a two-code medical emergency response system based on the instruction. Styal uses code blue to indicate an emergency when a prisoner is unconscious or having breathing difficulties, and code red for when a prisoner is bleeding. The control room should call an ambulance immediately when an emergency code is used.
105. The OSG did not use an emergency code. Instead, he radioed for healthcare staff to attend the first night centre. This did not convey that healthcare needed to attend a life-threatening incident immediately, as an emergency code would have done.

By chance two members of healthcare staff were close to the first night centre and diverted from their intended route to go there first. As a result, the failure to call an emergency code did not delay the healthcare response, as it might easily have done. However, the healthcare staff were not prepared for the situation they were to encounter and did not bring the emergency equipment with them as they would have done when responding to an emergency code. The failure to call an emergency code also meant that control room staff did not call an ambulance immediately and this led at least a three-minute delay before an ambulance was called.

106. The OSG said that he was aware of the emergency codes used at Styal but in the pressure of the situation, forgot to use one. While we appreciate he found himself in an unexpectedly shocking situation, in the absence of using a code, he needed to at least, convey the severity if the situation.
107. We are also concerned that the CM did not tell the OSG to call an emergency code but instead told him to ask healthcare and prison staff to attend. As Orderly Officer, we would have expected him to have understood the importance of calling a medical emergency code.
108. On 15 March 2019, following Ms McDonald's death, a notice to staff was issued reiterating the need to use the correct codes in a medical emergency. However, the OSG told the investigator that he was not aware of any guidance issued to staff since Ms McDonald's death, and some of the other staff the investigator interviewed remained unclear about when to use an emergency code.
109. It is evident that the Governor needs to do more to ensure that staff understand and follow emergency procedures. We make the following recommendation:

The Governor should ensure that all prison staff are made aware of and understand their responsibilities during medical emergencies, in particular that staff efficiently communicate the nature of a medical emergency using the appropriate code.

Future learning

110. We consider it important that frontline staff are able to learn from our investigations. We, therefore, make the following recommendations:

The Head of Healthcare should share this report with healthcare staff named in it and discuss its findings with them.

The Governor should ensure that this report is shared with the CM and the OSG and that a senior manager discusses our findings with them.

Inquest

111. The inquest into Ms McDonald's death concluded on 10 May 2024. It concluded that Ms McDonald died of suicide which was contributed to by failures of prison and healthcare staff.

**Prisons &
Probation**

Ombudsman
Independent Investigations

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T | 020 7633 4100