Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Ms Susan Knowles, a prisoner at HMP Styal, on 10 May 20

A report by the Prisons and Probation Ombudsman

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

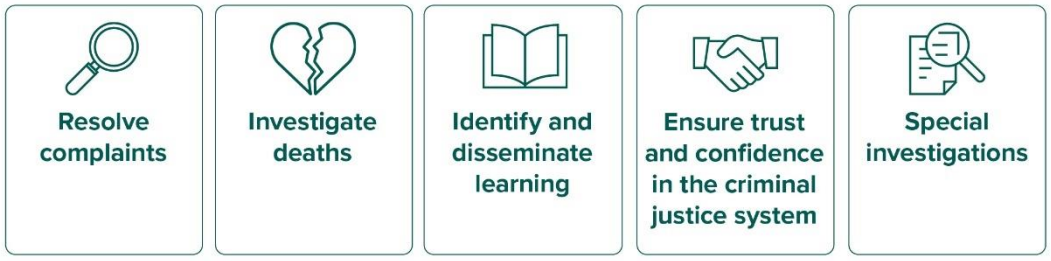
Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T l 020 7633 4100

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.

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 Susan Knowles was found hanged in her room at HMP Styal on 10 May 2019. She was 48 years old. I offer my condolences to Ms Knowles' family and friends.

Ms Knowles arrived at Styal on 8 May, two days before she died. She had heroin withdrawal symptoms but because of her low heart rate, healthcare staff decided to monitor her before giving her methadone. Ms Knowles subsequently refused to be assessed by healthcare staff, so they continued to withhold methadone. On 9 May, Ms Knowles said she would kill herself if she did not get her methadone. She was prescribed symptomatic relief and staff started suicide and self-harm monitoring (known as ACCT). Ms Knowles was found hanged that night.

I am not satisfied that Ms Knowles' withdrawal from drugs was appropriately managed. While it was appropriate for staff to withhold methadone, there was an unnecessary delay in prescribing symptomatic relief.

Ms Knowles arrived at Styal with several risk factors for suicide and self-harm, and I am concerned that staff did not start ACCT monitoring earlier. In addition, although staff did start ACCT monitoring 12 hours before Ms Knowles died, they did not carry out all the required observations on the night she died.

The officer who discovered Ms Knowles was not carrying a room key which resulted in a delay in entering her room. I am also concerned the officer did not call a medical emergency code when he discovered Ms Knowles, resulting in a delay in calling the ambulance. Failure to call a medical emergency code is something I have raised previously with Styal.

Ms Knowles was the fourth woman to die in the first night centre at Styal since February 2018. I am pleased to note that in response to our previous investigation findings and escalation to the Prison Group Director for women's prisons, Styal have made significant changes to reception and induction processes, including better monitoring of newly arrived prisoners withdrawing from drugs. I hope that these new measures will help prevent the failings we identified in Ms Knowles' case from happening again.

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 **February 2021**

Contents

Summary

Events

1. On 8 May 2019, Ms Susan Knowles was sentenced to eight weeks in prison for theft and breach of a Community Order and taken to HMP Styal. She had been to prison before and had a long history of substance misuse.

2. Ms Knowles arrived at Styal with documentation that said she had depression and anxiety and had recently reported suicidal thoughts. However, she told prison and healthcare staff that she had no thoughts of suicide or self-harm and no one started suicide and self-harm monitoring (known as ACCT).

3. Ms Knowles was showing heroin withdrawal symptoms when she arrived. However, as she had a low heart rate, staff decided to monitor her before giving her methadone (an opiate substitute which can affect the heart rate). Ms Knowles subsequently refused to have her withdrawal symptoms assessed or her heart rate monitored, so healthcare staff continued to withhold methadone.

4. On 9 May, Ms Knowles told staff that she would kill herself if she did not get her methadone. Prison staff started ACCT monitoring with two observations an hour. A nurse gave Ms Knowles symptomatic relief for her withdrawal symptoms.

5. On 10 May, at around 12.10am, an officer found Ms Knowles hanging from a shoelace tied to a door handle. He called for immediate healthcare assistance. He did not enter Ms Knowles' room as he had left the room key in his jacket pocket on the floor below. He asked another officer to fetch his jacket.

6. In the meantime, healthcare staff arrived and used their key to enter Ms Knowles' room. They started resuscitation attempts and told the officer to request an ambulance. The control room called for an ambulance at 12.18am. When ambulance paramedics arrived, they assessed that Ms Knowles was already dead and stopped resuscitation attempts.

Findings

7. We are concerned that reception staff failed to consider Ms Knowles' risk factors for suicide and self-harm when she arrived at Styal, and instead relied on her assurances that she had no thoughts of harming herself.

8. We are also concerned that the nurse who carried out Ms Knowles' initial health screen did not see the documentation that arrived with her. Styal has improved its reception procedures since Ms Knowles' death.

9. Although ACCT procedures were subsequently started, the night officer failed to carry out all the required ACCT observations on Ms Knowles on the night she died and made inaccurate entries on the ACCT record. The Governor commissioned a disciplinary investigation into his actions.

10. The clinical reviewer found that the standard of care Ms Knowles received for her physical health and substance misuse was not equivalent to that which she could

have expected to receive in the community. When Ms Knowles arrived at Styal, healthcare staff failed to carry out clinical observations on Ms Knowles every two hours as agreed and there was an unnecessary delay in prescribing symptomatic relief for Ms Knowles' heroin withdrawal.

11. There were also delays in the emergency response. The officer who found Ms Knowles did not call a medical emergency code, which delayed the calling of an ambulance, and he was unable to enter the room and start resuscitation attempts, because he did not have the room key with him. Although it made no difference in Ms Knowles' case as she was dead when she was found, such delays could be critical in other medical emergencies. The officer who found Ms Knowles was the same officer who failed to carry out ACCT checks and who was subject to a disciplinary investigation. He was dismissed on 21 January 2021.

12. Staff attempted to resuscitate Ms Knowles when she was clearly dead. This was inappropriate and contrary to resuscitation guidelines.

13. Since Ms Knowles' death, Styal have made significant changes to reception and induction processes, including better monitoring of newly arrived prisoners withdrawing from drugs.

Recommendations

- The Governor and Head of Healthcare should ensure that staff use an appropriate code to communicate a medical emergency.

- The Governor and Head of Healthcare should ensure that staff are given clear guidance about the circumstances in which resuscitation is inappropriate in accordance with European Resuscitation Council Guidelines.

The Investigation Process

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 her. Nobody responded.

15. The investigator visited Styal on 14 May 2019. She obtained copies of relevant extracts from Ms Knowles' prison and medical records. She visited the induction unit where Ms Knowles lived and spoke to prisoners and staff who had had contact with her.

16. The investigator made another visit to Styal on 11 September 2020, when she visited the newly located induction unit and obtained evidence of changes to the delivery of reception procedures, induction and healthcare provision.

17. NHS England commissioned a clinical reviewer to review Ms Knowles' clinical care at the prison.

18. The investigator interviewed two prisoners at Styal on in May 2019, and together with the clinical reviewer interviewed ten members of staff in September. In addition, the investigator interviewed two probation workers by telephone. The clinical reviewer also spoke to two healthcare staff.

19. We informed HM Coroner for Cheshire, Halton and Warrington of the investigation. The Coroner gave us the cause of death. We suspended our investigation in May 2019, pending the outcome of the police investigation, and resumed it in August 2020, when Cheshire Police told us that criminal charges would not proceed. We have sent the Coroner a copy of this report.

20. One of the Ombudsman's family liaison officers contacted Ms Knowles' brother to explain the investigation; he was contacted again by another family liaison officer, in August 2020. He did not respond.

21. The prison received a copy of the report and clarified a point about induction, the roles of two members of staff and the spelling of a surname which have been updated in this report. An action plan for the recommendations is annexed to the report.

Background Information

HMP Styal

22. 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.

23. Spectrum Community Health runs healthcare services at the prison. Greater Manchester West Mental Health NHS Foundation Trust provides mental health services. There are always nurses on duty 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

24. 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.

25. 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 stabilisation there was no routine night time monitoring and daytime monitoring was inconsistent and the lack of overnight observations during stabilisation created significant risks.

Independent Monitoring Board

26. 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 annual report, for the year to 30 April 2020, the IMB reported that the new Governor identified the safety of the prisoners and the security of the regime as key priorities. Consequently, there had been significant changes which had positively affected safety.

27. There had been three deaths in the first night centre (FNC) and the Board found the prison had responded to the recommendations made by the PPO in response to these deaths. The Board reported that the FNC had moved to Waite wing, where it was now known as the induction centre, and that all new prisoners would access a 28-day induction programme all new prisoners would access an induction programme lasting up to 28 days depending on individual need, with increased medical resources and support, including a nurse specifically designated to cover detoxification arrangements. A training package had also been prescribed for all staff working in this area, including training in suicide and self-harm prevention and trauma informed care.

28. The Board reported that the reception of prisoners into the prison continued to cause some concern. The Board noted that some of the reception staff were not always helpful to newly arrived prisoners and that the paperwork was voluminous. Prisoners complained to the Board that this took a very long time to complete and did not always provide an accurate record of property and medication.

Previous deaths at HMP Styal

29. Ms Knowles' death was the fifth at Styal since May 2017, and the fourth to occur in the first night centre since February 2018. Two of the previous deaths were self-inflicted, one was drug-related and one was from natural causes. We have previously made recommendations about assessing a prisoner's risk of suicide and self-harm, the monitoring of prisoners withdrawing from drugs and use of medical emergency codes. We found similar issues in this investigation, but there have been significant changes introduced at Styal since Ms Knowles' death.

30. Three prisoners have died since Ms Knowles. Two of these deaths were from natural causes and one (which is still being investigated) was self-inflicted. None took place in the first night centre or induction unit.

Assessment, Care in Custody and Teamwork (ACCT)

31. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner.

32. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular, multi-disciplinary review meetings involving the prisoner. As part of the process, a caremap (a plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the caremap have been completed.

33. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. 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

Wednesday 8 May

34. On 8 May 2019, Ms Susan Knowles was sentenced to eight weeks imprisonment for theft and breach of a Community Order and taken to HMP Styal. She had been in prison before.

35. Ms Knowles arrived at Styal with a Person Escort Record (PER - a document that accompanies all prisoners when they move between police stations, courts and prisons, which sets out the risks they pose) and a Suicide Risk Form that had been completed by her probation worker. The PER noted that Ms Knowles had depression/anxiety, that she had cut her wrists in 2007 and that she said she had had a heart attack 18 months ago. The Suicide Risk Form said that Ms Knowles had recently reported suicidal thoughts linked to her depression and drug use and that she was in receipt of antidepressant medication prescribed by her GP. (Staff requested her GP records the next day to confirm her medication, but they had not received a response before Ms Knowles died.)

36. An officer carried out Ms Knowles' reception screening and Cell Sharing Risk Assessment (CSRA). She recorded on the CSRA that Ms Knowles was withdrawing from drugs (heroin and crack cocaine), had depression and anxiety but had no current thoughts of self-harm. In response to the question, 'Has a suicide self-harm warning form been received?', the officer half circled 'no'. When asked about this at interview, she told the investigator that she could not recall what documentation she reviewed.

37. After Ms Knowles was taken to the first night centre (FNC), a nurse completed her initial health screen. She noted that the assessment was difficult because Ms Knowles was irritable because she was withdrawing from drugs and she said she felt unwell as she had not received her methadone (opiate substitute). Ms Knowles told the nurse that she was prescribed mirtazapine and amitriptyline (both antidepressants). The nurse told the investigator that she saw Ms Knowles' CSRA but did not see her PER or Suicide Risk Form. She noted that Ms Knowles had no thoughts of suicide or self-harm.

38. Ms Knowles' urine test was positive for opiates, cannabinoids and cocaine and she had signs of withdrawal: chills and flushing; runny nose; upset stomach and aching joints and muscles. She scored 9 on the Clinical Opiate Withdrawal Scale (COWS), indicating a low level of withdrawal. The nurse recorded that Ms Knowles had a low temperature (35.5°C), low pulse (44 beats per minute) and low respiratory rate (11 breaths per minute), resulting in a National Early Warning Score (NEWS) of 3. (The NEWS tool determines clinical deterioration and prompts critical care intervention. A score between 0 and 4 indicates low to medium clinical risk and requires that a patient is monitored.) Ms Knowles refused blood tests and an electrocardiogram (ECG – a test to check the heart's rhythm). The nurse noted that Ms Knowles should be monitored every two hours and sent to A&E if her health deteriorated.

39. The nurse also noted that Ms Knowles should not be given methadone treatment that evening because she had a slow heart rate and would need to be reassessed by the drug and alcohol rehabilitation services (DARS) the next day.

40. At 11.35pm, a nurse noted in Ms Knowles' medical record that her two hourly observations were late as she was dealing with another incident. Ms Knowles had demanded her methadone and remained irritated when the nurse explained why she was not prescribed methadone (because her heart rate was low, and methadone could reduce that further). She noted Ms Knowles' NEWS score as 2 and her COWS score as 9. Ms Knowles said that she would refuse to be assessed further during the night.

Thursday 9 May

41. At 2.13am, the nurse noted that she had tried to take Ms Knowles' observations, but Ms Knowles had refused and said she wanted to be left alone. There are no further entries on Ms Knowles' medical record for the night shift.

42. At 10.39am, a nurse noted that she would ask the DARS team to assess Ms Knowles as she had not yet been prescribed her methadone.

43. At 11.11am, a prison chaplain, noted that she had tried to talk to Ms Knowles but she was detoxing quite badly and would not speak to her.

44. At 11.15am, a nurse tried to complete the secondary health screen, but Ms Knowles refused to engage apart from having her pulse taken, which was 43 beats per minute. The nurse noted that Ms Knowles refused to have her blood pressure taken or an ECG to see why her pulse was so low. She noted that she advised Ms Knowles that she would not be prescribed any medication or methadone if she was non-compliant with assessments, but she still refused. The nurse informed the matron.

45. At 12.10pm, an officer started suicide and self-harm procedures (known as ACCT) after Ms Knowles said she was withdrawing from heroin, was in a lot of pain and discomfort and would kill herself if she did not get her methadone. A supervising officer completed the immediate action plan at 12.20pm and set observations at two an hour.

46. At 12.21pm a drug and alcohol recovery worker, saw Ms Knowles. Initially she refused to engage and swore at him, but he persuaded Ms Knowles to engage and he completed a drug assessment and treatment plan. He recorded that Ms Knowles said she had no thoughts of suicide or self-harm.

47. At 2.29pm, a nurse Messenger noted that Ms Knowles had declined a mental health assessment as she felt too unwell due to her withdrawal symptoms.

48. At 2.47pm, the matron prescribed symptomatic relief for Ms Knowles' drug withdrawal: pain relief (ibuprofen and paracetamol); loperamide, mebeverine and quinine sulphate to reduce diarrhoea and stomach cramps; and anti-sickness medication (metoclopramide).

49. At 3.37pm, a healthcare support worker, went to the first night centre with a healthcare assistant, to examine Ms Knowles. The healthcare support worker noted in Ms Knowles' medical record that she was uncomfortable due to withdrawing from opiates and could not lie on the bed long enough to have a good quality ECG. Ms Knowles said she had severe aching in her joints and muscles

and that her pupils were dilated. Ms Knowles scored 15 on the COWS, indicating moderate signs of withdrawal. A healthcare support worker noted that she had discussed Ms Knowles with the matron who suggested they attempt an ECG later and that Ms Knowles should be given symptomatic relief. This medication was administered to Ms Knowles at 5.30pm.

50. Closed Circuit Television (CCTV) on the induction wing was provided to the investigator but could not be viewed as the disc would not play. Cheshire Police viewed the footage and provided a timeline of events. Cheshire Police said that the time stamp on the footage was around eight minutes fast. The times below are actual times.

51. At around 8.00pm, Ms Knowles collected more symptomatic relief medication from the medication hatch. A prisoner, said she saw Ms Knowles in the queue for medication and that she was crouched on the floor with her nightdress pulled over her knees. The prisoner said Ms Knowles appeared weak with typical symptoms of heroin withdrawal.

52. At 8.25pm, a nurse noted that Ms Knowles' pulse remained low and that she should stay on symptomatic relief until assessment.

53. CCTV shows that an officer checked on Ms Knowles at 8.25pm. He made an entry on the ongoing record at 8.40pm saying that Ms Knowles was awake and that she said she was okay. CCTV shows that at 9.03pm, the officer went to the left-hand room next to Ms Knowles but did not check her room.

54. CCTV shows that at 9.21pm, an officer checked Ms Knowles. He made an entry at 9.30pm on the ongoing record saying that Ms Knowles was lying on her back and breathing was noted.

55. CCTV shows at 9.36pm, the officer checked the right-hand room next to Ms Knowles, but he did not check her room. He made an entry on Ms Knowles' ongoing record at 10.00pm saying that Ms Knowles was lying on her back and breathing was noted.

56. CCTV shows that at 10.10pm, an officer went to the room on the left of Ms Knowles, let the prisoner out, and they both left. They returned at 10.33pm and the officer locked the prisoner in her room. He did not check on Ms Knowles.

57. CCTV shows that at 10.42pm, an officer went to Ms Knowles' room. At 10.53pm, two officers went to the room to the right-hand side of Ms Knowles' room, but they did not check her room. One of the officers made an entry on Ms Knowles' ongoing record at 11.10pm; 'x2 checks in the hour lay on her left side knocked on the door to get a response Susan stuck her 2 fingers up at the door no concerns raised'. This entry had originally been recorded as 11.00pm, but the time had been overwritten.

58. CCTV shows that at 11.04pm, two nurses attended the rooms either side of Ms Knowles and spent four minutes talking to those prisoners. They did not check Ms Knowles. Five minutes later, a nurse went back to the room on the right-hand side of Ms Knowles' room. She did not check Ms Knowles.

Friday 10 May

59. At 12.10am, during an ACCT check, the officer saw Ms Knowles hanging by a shoelace attached to the toilet door handle. He used his radio to call for immediate healthcare assistance to attend the first night centre. Officers do not carry cell/room keys on their key chains at night but have a key in a sealed pouch for use in an emergency. The officer did not have the sealed pouch as it was in his jacket pocket which was in an office on the floor below; he asked an officer to go and get his jacket.

60. A nurse responded to the call for assistance along with a healthcare assistant. The nurse unlocked the door. She said that when she arrived at the room, she felt it was necessary to enter the room straightaway and not wait for other officers to attend because it was obviously an emergency. The officer removed the ligature from Ms Knowles and the nurse started cardiopulmonary resuscitation (CPR) and told the officer to request an ambulance.

61. Other prison and healthcare staff responded to the request for assistance. An officer assisted the healthcare assistant to get emergency lifesaving equipment, including a defibrillator, from the healthcare room on the first night centre. An officer helped move Ms Knowles onto the landing outside her room for more space, and she took over chest compressions while the nurse administered oxygen via an ambu-bag. Initially, the oxygen could not be located by the officer but with further direction it was found and given to the nurse.

62. North West Ambulance Service records show they received a request for an ambulance at 12.18am. Paramedics arrived at Ms Knowles' room at 12.33am. They noted that Ms Knowles had deep red ligature marks around her neck, that her pupils were fixed and dilated, that she was cold to touch and was beyond resuscitation. They declared her death at 12.34am.

Contact with Ms Knowles' family

63. The prison appointed a prison family liaison officer. There was a delay in identifying Ms Knowles' next of kin as she did not provide details when she arrived at Styal. Styal obtained the contact details of one of her siblings but were advised that they should not break the news to him without him having support in place. Another sibling was identified and at 3.00pm on 11 May, the prison family liaison officer and a prison manager visited Ms Knowles' family to break the news of her death and offered support. In line with national instructions, the prison contributed towards the cost of the funeral, which was held on 31 May.

Support for prisoners and staff

64. The custodial manager and duty governor, debriefed the prison and healthcare staff involved in the emergency response and offered their support and that of the staff care team.

65. The prison posted notices informing prisoners of Ms Knowles' death and offering support. Staff reviewed all prisoners assessed as at risk of suicide and self-harm, in case they had been adversely affected by Ms Knowles' death.

Post-mortem report

66. A pathologist concluded that Ms Knowles died from hanging. Toxicology results showed traces of cocaine, heroin, methadone and gabapentin (a prescription drug that is widely abused), but the concentrations indicated that these drugs had been consumed before Ms Knowles entered custody. The only drug identified that had been taken recently and had not been prescribed to Ms Knowles was cetirizine, an antihistamine.

Findings

Assessment and management of Ms Knowles' risk of suicide and self-harm

Reception and induction procedures

67. Prison Service Instruction (PSI) 64/2011, Management of prisoners at risk to self, to others and from others (Safer Custody), sets out the procedures (known as ACCT) that staff should follow where they identify that a prisoner is at risk of suicide or self-harm. The PSI lists potential risk factors and triggers that might increase the risk of suicide and self-harm.

68. PSI 07/2015, Early Days in Custody, says that all prisoners should be risk assessed for potential harm to themselves, to others and from others and that the Person Escort Record (PER) and any other available documentation must be examined in reception to assess for risk factors.

69. Ms Knowles arrived at Styal with a PER that said she had anxiety and depression and a Suicide Risk Form that said she had recently reported suicidal thoughts. She also had a history of drug misuse and had drug withdrawal symptoms, also risk factors for suicide and self-harm. We are concerned that staff failed to consider Ms Knowles' risk factors for suicide and self-harm when she arrived at Styal.

70. An officer said she did not recall Ms Knowles' reception interview. She told the investigator that she would have based her assessment on the PER and what Ms Knowles told her. She did not remember seeing the Suicide Risk Form and could not explain why it was not referenced anywhere.

71. A nurse told the investigator that she only ever had the CSRA to refer to when carrying out the reception health screens; she never saw the PER or any other documents, which remained in reception and were not passed to the first night centre. We are concerned that the nurse did not see documents that were relevant for assessing Ms Knowles' risk of suicide and self-harm.

72. In a thematic report about risk factors in self-inflicted deaths published by the Prisons and Probation Ombudsman in April 2014, we identified that too often reception assessments place too much weight on staff's perception of the prisoner and they do not consider all relevant information. We reinforced these messages in a Learning Lessons Bulletin, issued in February 2016, about early days and weeks in custody. All risk factors must be collated and considered to ensure that a prisoner's level of risk is judged holistically.

73. In our last investigation into a self-inflicted death at Styal, which happened in March 2019, we also found that reception staff had failed to assess the prisoner's risk factors for suicide and self-harm and had placed too much reliance on the prisoner's own statements that they had no suicidal thoughts. In response to our recommendation, the prison said that training would be delivered to reception, induction and healthcare staff on defensible decision making, including considering all evidenced risk factors and properly recording the decisions made. It also said

that a new Safety Strategy would be introduced in March/April 2020, which would include clear procedures for sharing information relevant to risk, such as the PER.

74. We have also been told that since September 2019, the prison has employed an additional nurse to support the reception process and nurses have been reminded of the importance of assessing and recording all known risks, including those on the PER and any warning forms. A dedicated healthcare room has been provided in reception and a nurse is based there throughout the day.

75. Given the improvements made to reception and induction procedures, we do not make a recommendation.

ACCT observations on the night of 9/10 May

76. When staff started ACCT monitoring for Ms Knowles on 9 May, they set observations at two an hour. However, the ACCT ongoing record has the following entries from 8.40pm on the evening that Ms Knowles died: 8.40pm, 9.30pm, 10.00pm, 11.10pm and 12.10am (when Ms Knowles was found). Based on the ongoing record alone, checks were not made twice an hour. In addition, CCTV shows that the officer only made checks on Ms Knowles at 8.25pm (8.33pm on CCTV), 9.21pm (9.29pm on CCTV) and 10.42pm (10.50pm on CCTV). There was no 10.00pm check and while the 11.10pm entry (which had been altered from 11.00pm) says that two observations had been completed in the previous hour, CCTV shows this was not the case. We are also concerned that the times recorded on the ACCT ongoing record did not correspond with the actual times of the checks. PSI 64/2011 says, 'Staff must follow the level of observations and conversations as stated in the 'required frequency of conversations and observations' box on the front cover of the ACCT. These must be recorded immediately or as soon as practicable thereafter'.

77. At the time Ms Knowles was at Styal, an operational support grade (OSG) was detailed to act as the night patrol officer in the first night centre. On the night of 9-10 May there was a short fall of OSGs and the night manager asked the officer to cover this role due to his experience on nights. The officer had worked as an OSG for around four years (one year on permanent nights) before he completed his prison officer training, had experience of working on the first night centre and was familiar with the routine and requirement for observations. The officer agreed, although he was expecting to shadow a more experienced officer himself, as it was his first set of nights after his prison officer training. An officer who a newly qualified officer was also, went with him to shadow the night shift and the officer said he spent additional time assisting her and answering questions.

78. The officer said that it was common practice to use a matrix for recording ACCT checks; this is not an official document, but he used it to note who needed to be checked and the frequency, which would then be recorded later into the ACCT document. He told the Head of Safer Prisons & Equality that he could not recall why he did not complete all the observations for Ms Knowles. He thought he had amended the ACCT entry at 11.10pm because he realised he had made an error.

79. We do not know what time Ms Knowles died but it is possible that she would have been found sooner had ACCT observations been carried out at the required

frequency. The Governor commissioned a disciplinary investigation into the officer actions in line with PSI 06/2010, Conduct and Discipline. The officer was dismissed on 21 January 2021. We therefore make no recommendation.

Clinical care

80. Overall the clinical reviewer found that the primary and substance misuse care Ms Knowles received was not of the required standard and was not therefore equivalent to the care she could have expected to receive in the community. We cannot say whether these failings directly impacted on Ms Knowles' decision to take her own life.

Physical health

81. The clinical reviewer found that staff promptly identified Ms Knowles' poor health, used the NEWS score appropriately to identify possible acute illness, and requested appropriate diagnostic tests. However, on Ms Knowles' first night in prison, she should have had clinical observations taken every two hours but the 4.00am and 6.00am observations were missed, and there was no entry on the medical record to explain why these observations were not done.

82. In April 2020, Styal introduced a new induction unit (Waite Wing) which replaced the first night centre where all newly arrived prisoners are located for at least 14 days. The induction unit has dedicated healthcare staff and prison staff based in one area and a registered nurse is always on duty. The cell doors have a large observation hatch for improved observation and communication and allows medications to be easily administered.

83. Given the changes introduced since Ms Knowles' death, we make no recommendation.

Management of withdrawal symptoms

84. The clinical reviewer considered that the decision not to prescribe methadone when Ms Knowles arrived was clinically appropriate (due to her slow heart rate). However, there was a lengthy delay in prescribing symptomatic relief medicines and no obvious reason to withhold those. A nurse said that she was concerned about Ms Knowles' clinical presentation and the possibility that she may have had an infection, but she accepted the failure to prescribe symptomatic relief was an oversight.

85. We consider that the failure to prescribe symptomatic relief promptly was a serious omission. Ms Knowles was suffering withdrawal symptoms and the lengthy delay in relieving these may have affected her mood.

86. Styal told us that since June 2020, prisoners who are alcohol dependent, opioid dependent and those prescribed opioid substitution treatments, are checked at four hourly intervals during the night and twice during the day for the first five days, with a review on day nine. The substance misuse manager makes daily checks to ensure the process is being followed, observations are carried out and recorded and that prisoners who require symptomatic relief are prescribed medications without delay.

87. We acknowledge that Styal has made changes to the monitoring of prisoners withdrawing from opioids and there are processes in place to ensure that those who need symptomatic relief are prescribed appropriate medication without delay. We therefore make no recommendation.

Mental health

88. The mental healthcare Ms Knowles received was found by the clinical reviewer to be largely equivalent to the care she could have expected to receive in the community. However, key information that arrived with Ms Knowles relating to her risk of suicide and self-harm was not known, which meant the management of her mental health was potentially compromised.

Emergency Response

Medical emergency code

89. Styal's local protocol is clear that an ambulance should be called immediately, when a medical emergency code is radioed, in line with PSI 03/2013 – Medical Emergency Response Codes. When the officer discovered Ms Knowles, he used his radio to request immediate healthcare assistance, but he did not use a code blue medical emergency. Healthcare staff responding to the request for assistance did not collect the emergency medical bag, as they did not know what the situation was until after they arrived at Ms Knowles' room, and as an emergency code had not been called, the control room did not call an ambulance. There was therefore a delay of around eight minutes before an ambulance was requested. Although the delay made no difference in Ms Knowles' case, we know that in a medical emergency a delay of a few minutes may be critical. We have previously identified not using the appropriate medical emergency code as an issue at Styal and we repeat our recommendation:

The Governor and Head of Healthcare should ensure that staff use an appropriate code to communicate a medical emergency.

Entering Ms Knowles' room

90. PSI 24/2011 - Management and Security of Nights, gives national guidance for entering cells at night. The PSI says that under normal circumstances, the night orderly officer must give authority to unlock a cell at night and a cell must be opened with a minimum number of staffs present (according to local risk guidelines). However, the PSI goes on to say that the preservation of life must take precedence over this. Where there is or appears to be threat to life, staff may open and enter cells on their own if they feel safe to do so, having performed a dynamic risk assessment and informed the control room.

91. Officers do not carry cell/room keys on their key chains at night but have a key in a sealed pouch for use in an emergency. The officer said in his initial prison statement that he was struggling to break the seal to access the key, when the nurse arrived and opened the door around one minute and 20 seconds after Ms Knowles was first discovered. However, during a subsequent police investigation it

transpired that the officer did not have the sealed pouch with him when he checked on Ms Knowles, as he had left it in his jacket pocket.

92. The officer said that he thought the sealed pouch had to be on the unit and that he did not know it had to be attached to his belt or that that the Local Security Strategy states: 'pouch should be collected from the gate lodge and secured to the person before leaving the confines of the gate lodge… they'll be fixed to key chains at all times during shift'. As well as causing a delay, this was, therefore a security breach.

93. The officer was suspended from duty on 11 May 2019. Cheshire Police conducted a criminal investigation, but the decision was made in August 2020 not to pursue criminal charges. The Governor immediately commissioned a disciplinary investigation into the officer's actions in line with PSI 06/2010 Conduct and Discipline, which we would otherwise have recommended.

94. The Governor issued a Notice to Staff reminding them of the need to ensure sealed pouches are attached and night managers are now required to check staff understand their responsibilities. This is reinforced by the Local Security Strategy.

95. Given the action already taken by Styal, we make no recommendation.

Resuscitation

96. In September 2016, The National Medical Director at NHS England wrote to Heads of Healthcare for prisons and Immigration Removal Centres introducing new guidance to support staff on when not to perform cardiopulmonary resuscitation. This guidance was designed to address the issue of inappropriate resuscitation following a sudden death in a prison and was based on the European Resuscitation Council Guidelines 2015 which state, "Resuscitation is inappropriate and should not be provided when there is clear evidence that it will be futile".

97. A nurse said Ms Knowles was clearly dead. Paramedics recorded there were obvious signs of death when they assessed Ms Knowles: there was no circulation, her pupils were fixed and dilated, she was cold to the touch and signs of blood pooling were present, all indicators that she had been dead for some time.

98. Staff should have recognised that Ms Knowles was dead and should not have carried out CPR in these circumstances. Trying to resuscitate someone who is clearly dead is distressing for staff and undignified for the deceased. We therefore make the following recommendation:

The Governor and Head of Healthcare should ensure that staff are given clear guidance about the circumstances in which resuscitation is inappropriate in accordance with European Resuscitation Council Guidelines.

Inquest

99. The inquest into Ms Knowles' death concluded in October 2024, and that her cause of death was compression of the neck due to low hanging. The inquest found that the lack of continued symptomatic relief medication and the failure to conduct checks after 10.41pm on 9 May possibly contributed to her death.

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 l 020 7633 4100