Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Ms Ann-Marie Pyle, a prisoner at HMP Drake Hall, on 30 September 2021

A report by the Prisons and Probation Ombudsman

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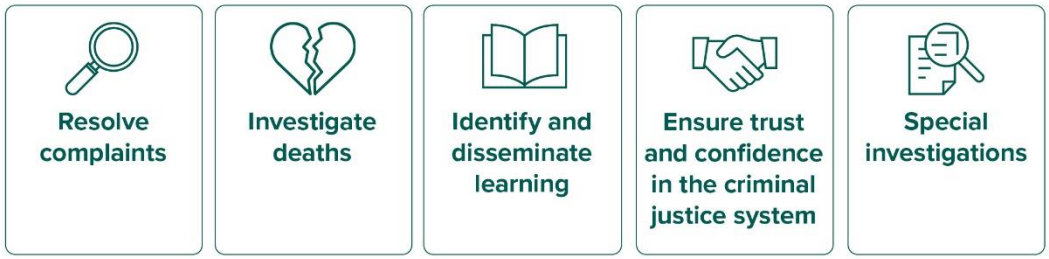
OUR VISION

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

WHAT WE DO



WHAT WE VALUE

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

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 Ann-Marie Pyle died of ischaemic heart disease caused by coronary artery atheroma (a build-up of plaque in the arteries around the heart) on 30 September 2021, while a prisoner at HMP Drake Hall. She was 61 years old. I offer my condolences to those who knew her.

The clinical reviewer concluded that overall, the clinical care provided to Ms Pyle was not equivalent to that which she could have expected to receive in the community. She found that when Ms Pyle's cholesterol levels and blood pressure were identified as raised, no follow-up action taken to address the associated risks. It is not possible to say whether this impacted on the outcome for Ms Pyle, but we are concerned that the same practice might impact on outcomes for other patients.

We found no non-clinical issues of concern.

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

Kimberley Bingham
Acting Prisons and Probation Ombudsman **December 2022**

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Summary

Events

1. Ms Ann-Marie Pyle was serving a life sentence for manslaughter. She had served time in several prisons before moving to Drake Hall in 2018.

2. Ms Pyle was not comfortable around men and the prison healthcare team provided female-led care wherever possible. This was more difficult to control when Ms Pyle required support from the community hospital, which could not guarantee the availability of female staff.

3. Ms Pyle's cholesterol levels had been above average for two years and she took regular prescribed medication to manage this. Her levels were supposed to be checked annually, but there is no evidence of a test in 2021.

4. On 14 September 2021, Ms Pyle's blood pressure was recorded as high for the first time. There is no evidence that action was taken in response to this.

5. At around 7.00am on 30 September, an officer checked that Ms Pyle was in her room during the morning roll check. She thought that she was asleep, so did not try to talk to her. Later that morning, Ms Pyle did not attend her workplace. At around 8.45am, an officer found Ms Pyle unresponsive in her room and radioed an emergency code.

6. Healthcare staff arrived and assessed that rigor mortis was present so did not continue to try to resuscitate Ms Pyle, in line with national guidelines. Paramedics arrived at 9.10am and confirmed her death at 9.30am.

7. The post-mortem examination found that Ms Pyle died of heart disease.

Findings

8. When Ms Pyle refused to engage with male professionals, the healthcare team at Drake Hall ensured that clinical care was female-led, wherever possible. This was outside their control when Ms Pyle attended the local hospital.

9. Ms Pyle died unexpectedly. However, healthcare staff did not follow national guidelines when managing her cholesterol levels and blood pressure before her death. When raised readings were taken, no follow-up action was taken to address the associated risks.

Recommendations

- The Head of Healthcare at HMP Drake Hall should ensure that healthcare staff take appropriate action in response to abnormal readings for blood pressure and cholesterol, in line with the National Institute for Health and Care Excellence (NICE) guidelines.

The Investigation Process

10. The investigator issued notices to staff and prisoners at HMP Drake Hall informing them of the investigation and asking anyone with relevant information to contact her. One resident made contact with the investigator and was interviewed by telephone.

11. The investigator visited HMP Drake Hall on 22 November 2021. She obtained copies of relevant extracts from Ms Pyle's prison and medical records and interviewed six members of staff.

12. NHS England commissioned an independent clinical reviewer to review Ms Pyle's clinical care at the prison. The clinical reviewer conducted joint interviews with the investigator and healthcare staff by video conference on 22 November.

13. We informed HM Coroner for Staffordshire South of our investigation. The Coroner gave us the results of the post-mortem examination. We have sent him a copy of this report.

14. The Ombudsman's family liaison officer confirmed with the prison that Ms Pyle did not identify a next of kin.

15. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not identify any factual inaccuracies.

Background Information

HMP Drake Hall

16. HMP/YOI Drake Hall is a prison in Staffordshire, holding approximately 320 adult and young adult women who are on remand or sentenced. Drake Hall is a closed prison with an open regime, which means that women are never locked in their rooms and have free access around the site during the day. At night, they are locked in their houseblocks, but able to move around these units freely. Care UK provides health services from 7.15am to 6.30pm weekdays and 7.30am to 5.00pm at weekends.

Her Majesty's Inspectorate of Prisons (HMIP)

17. The most recent inspection of Drake Hall was in February 2020. Inspectors reported that the prison remained a safe place to live, with minimal instances of serious violence. They found that prisoners were positive about the community ethos.

18. Healthcare provision had improved since the last inspection and was considered to be good. Prisoners had good access to a range of primary care services which includes a female GP and specialist counselling. The level of missed appointments remained high. However, overall waiting times for appointments were within acceptable time frames.

Independent Monitoring Board

19. 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 October 2020, the IMB reported that that HMP Drake Hall provided a safe and secure environment for prisoners, and that the prison is managed effectively.

20. Overall, the Board were satisfied with the standard of healthcare at the prison. They suggested that missed medical appointments decreased during the COVID-19 pandemic as prisoners were escorted to all appointments.

Previous deaths at HMP Drake Hall

21. The last death at HMP Drake Hall took place in 2018. There are no similarities in our findings across these investigations.

Key Events

22. On 15 July 2002, Ms Ann-Marie Pyle was sentenced to life imprisonment for manslaughter. She served time in a number of prisons and was transferred to HMP Drake Hall on 29 June 2018. On arrival at Drake Hall, healthcare staff identified and recorded Ms Pyle's long-term health conditions, including high cholesterol and joint pain. These conditions were managed by prescribed medication, which was provided, and required regular monitoring.

23. On 30 July 2018, during a routine mental health assessment, Ms Pyle told a nurse that she was not happy consulting male professionals, including prison doctors. The healthcare team reflected this in Ms Pyle's care plan.

24. In 2019, Ms Pyle was diagnosed with an underactive thyroid gland.

25. In February 2021, Ms Pyle's blood sugar was identified as raised and she was diagnosed with Type 2 diabetes. She was referred to the community diabetes service but declined the two telephone consultations that were offered. She asked to be discharged from the service.

26. On 24 July, Ms Pyle's medication was reviewed by the prison pharmacist. She asked for the prison GP to review Ms Pyle, following blood tests taken to review thyroid function.

27. On 2 August, a prison GP recorded that Ms Pyle's blood test results were normal and that her average blood sugar level was slightly above the normal range. She noted that no further action was required. A review appointment was organised with a female GP on 17 August 2021. Ms Pyle declined to attend.

28. On 13 September 2021, Ms Pyle told staff that she felt unwell and had cold symptoms. A nurse reviewed Ms Pyle on 13 and 14 September and recorded that her temperature, pulse and blood oxygen levels were within the normal range on both days. However, on 14 September, the nurse recorded that Ms Pyle's blood pressure was raised.

29. At around 1.00pm on 29 September, two officers saw Ms Pyle during lunch. Both officers said that there was nothing unusual about her presentation. They said that she was excited about her temporary release the next day.

30. At 7.00pm, an officer conducted roll checks. He counted Ms Pyle, who was in her room. At interview, he did not recall anything unusual or concerning and was not informed of any concerns about Ms Pyle during his shift, which finished at 9.00pm.

31. Night staff conducted further roll checks at approximately 10.00pm. Roll checks did not involve any verbal interaction with prisoners unless they were subject to welfare or monitoring checks, which Ms Pyle was not. She did not ring her room bell for assistance during the night.

Events of 30 September 2021

32. At around 7.00am on 30 September, an officer completed the morning roll check. She observed that Ms Pyle was sleeping in her bed.

33. At 8.00am on 30 September, Officer A started her shift. That morning, she was responsible for checking that all prisoners had attended their activities.

34. At approximately 8.30am, a Custodial Manager (CM) told Officer A that three women, including Ms Pyle, had not attended their workplaces and asked her to check on them. The officer checked on Ms Pyle first. She arrived at her room at about 8.45am and looked in her doorway (her door was unlocked because Durham House, where Ms Pyle lived, operates an open regime). She thought that Ms Pyle was asleep in her bed, under the covers, but she did not get a response when she shouted her name repeatedly. She immediately called for assistance. A prison contractor was near Ms Pyle's room at the time. She asked him to stand outside Ms Pyle's room while she went in. She was concerned that Ms Pyle was not responding and did not want to wait any longer for assistance before going into her room.

35. Officer A went into Ms Pyle's room and tapped her shoulder. There was no response. She touched Ms Pyle's forehead which was cold. She noticed that Ms Pyle was pale, and her lips looked blue and purple. She radioed a code blue (a medical emergency code indicating that a prisoner is having difficulty breathing) and asked for staff assistance again at 8.50am. An emergency ambulance was called immediately at 8.50am.

36. Officer B and a Senior Officer (SO) heard the call for assistance and arrived at Ms Pyle's room at approximately 8.54am. Officer B noted that her skin was cold and confirmed that she could not find a pulse. The SO and Officer B moved Ms Pyle from her bed to the floor and started cardiopulmonary resuscitation (CPR). Officer A left the room to find further support.

37. Two nurses arrived at 8.57am in response to the emergency call for assistance. They took over CPR. The Head of Healthcare arrived at 9.00am. At 9.03am, the Head of Healthcare told staff to stop CPR because it was clear that Ms Pyle was dead. This was in line with current UK resuscitation guidelines. The ambulance arrived at 9.10am and paramedics confirmed at 9.30am that Ms Pyle had died.

Support for prisoners and staff

38. After Ms Pyle's death, a prison 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.

39. The prison posted notices informing other prisoners of Ms Pyle'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 Pyle's death.

Post-mortem report

40. The Coroner concluded that Ms Pyle died from ischaemic heart disease (a heart problem caused by narrowed heart arteries reducing blood and oxygen flow to the heart), caused by coronary artery atheroma (a build-up of plaque in the arteries around the heart).

Findings

41. The clinical reviewer concluded that, overall, Ms Pyle's clinical care was not equivalent to that which she could have expected to receive in the community.

42. Ms Pyle made it clear to staff that she did not want to consult with male professionals. This was well managed by the healthcare team at Drake Hall, who were able to provide female-led clinical support. When clinical support was required outside the prison, at the local hospital, female professionals were always requested when arranging appointments. When Ms Pyle did not attend arranged appointments, prison staff consistently followed up and encouraged engagement. We are satisfied that, in doing so, they made every effort to ensure that Ms Pyle's health was appropriately monitored.

43. When Ms Pyle's cholesterol and blood pressure readings were raised, healthcare staff did not take action to mitigate the associated risks in line with national guidelines. We accept that Ms Pyle might have had her cholesterol reviewed if she attended the diabetic clinic in February 2021 and had not discharged herself from the service. This may have led to further investigations that might have identified heart disease.

44. While it is not possible to conclude whether failure to follow up the readings was linked to Ms Pyle's death, high cholesterol and high blood pressure can contribute to ischemic heart disease. We are concerned that this practice might impact on outcomes for future patients, and we make the following recommendation:

    The Head of Healthcare at HMP Drake Hall should ensure that healthcare staff take appropriate action in response to abnormal readings for blood pressure and cholesterol, in line with the National Institute for Health and Care Excellence (NICE) guidelines.

45. The clinical reviewer identified a number of issues which were not directly linked to Ms Pyle's death, but which the Head of Healthcare will need to address.

Inquest

46. The inquest, held on 9 September 2024, concluded that Ms Pyle died from natural causes.

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