Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Ms Lorna Carter, a prisoner at HMP Styal, on 27 January 2025

A report by the Prisons and Probation Ombudsman

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

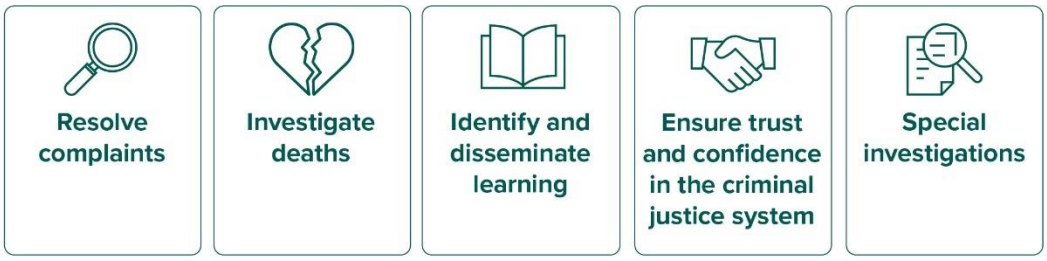
Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T I 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

1. 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.

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

3. On 23 November 2024, Ms Lorna Carter was remanded in prison charged with drug offences. She died in hospital of multiorgan failure (due to liver cirrhosis, heart failure and pneumonia) on 27 January 2025, while a prisoner at HMP Styal. She was 58 years old. We offer our condolences to Ms Carter's family and friends.

4. The Ombudsman's office wrote to Ms Carter's next of kin to explain the investigation and to ask if they had any matters they wanted us to consider. They asked questions about Ms Carter's healthcare which have been addressed in the clinical review. They asked some other questions which have been addressed in separate correspondence.

5. The PPO investigator investigated the non-clinical issues relating to Ms Carter's care. We did not find any non-clinical issues of concern.

6. NHS England commissioned an independent clinical reviewer to review Ms Carter's clinical care at HMP Styal.

7. The clinical reviewer concluded that the clinical care Ms Carter received at Styal was of a variable standard and only partially equivalent to that which she could have expected to receive in the community.

8. She found that when Ms Carter discharged herself from hospital on 22 December against medical advice, she was not seen by healthcare staff when she returned to the prison and her clinical observations were not taken until three days later. This meant that Ms Carter's baseline observations were not taken (nor a NEWS2 score calculated, a tool to assess clinical deterioration) on her return from hospital, which would have informed the need for escalation if her condition changed. We recommend:

   The Head of Healthcare should ensure that, when a patient returns from hospital following A&E attendance, they are reviewed and clinical observations, including NEWS2, are taken.

9. The clinical reviewer also made recommendations not directly related to Ms Carter's death which the Head of Healthcare will wish to address.

10. We shared our initial report with HMPPS and the prison's healthcare provider, Spectrum Community Health CIC. They found no factual inaccuracies. Spectrum Community Health CIC provided an action plan which is annexed to this report.

11. We sent a copy of our initial report to Ms Carter's next of kin. They did not notify us of any factual inaccuracies.

Adrian Usher **July 2025**
Prisons and Probation Ombudsman

Inquest

At the inquest, held on 20 January 2026, the Coroner concluded that Ms Carter died from natural causes.

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 I 020 7633 4100