The death in custody of a woman and the series of deaths in HMP/YOI Styal August 2002 – August 2003

Report by the Prisons and Probation Ombudsman for England and Wales

October 2003

Preface to the published version

This published version of the report of my inquiry into the death of a woman at Styal prison, which also looked at the deaths of five other women, comes some two years after the report itself was written. I much regret the delay, but the simple fact is that the report could not be made public until all the inquests were concluded. I fear that publication may cause fresh anguish to the bereaved after what has already been a prolonged process of investigation and inquiry. But I hope that this is mitigated by the value of putting the facts of what happened fully into the public domain.

Apart from some very minor amendments, and removal of the names of those involved, the text of my report is as I submitted it in October 2003. The reader will therefore need to bear in mind that the report reflects the position then, and not the position now. Much has changed at Styal, and the Prison Service has acted on many of my recommendations. In addition, since April 2004 my office has been responsible for all investigations into deaths occurring in prisons in England and Wales.

The inquest into the death of the woman that led to my investigation and who is at the centre of this report was held in April 2005. The jury's verdict was as follows.

> 'At 7.30 pm on 12th August 2003, the deceased … voluntarily consumed a lethal amount of dothiepin in the showers on Y side of Waite Wing, Styal prison.
>
> She had previously taken a prescribed dose of dihydrocodeine and possibly additional unprescribed dihydrocodeine.
>
> Her death was an unintentional consequence of her action. The contributing factor to her death was the failure of the nurse to secure the medication on the trolley. This provided an opportunity for the bottle of dothiepin to be taken.'

Stephen Shaw
Prisons and Probation Ombudsman **November 2005**

Preface to the originally submitted version

This is the report of an investigation into the circumstances of the death of a woman at HMP/YOI Styal on 12 August 2003. I was also charged with examining the series of self-inflicted deaths of prisoners at HMP Styal since 10 August 2002 to establish whether common issues were apparent.

Condolences from strangers offer scant comfort to those who are bereaved. Having met a number of relatives of those who have died in Styal, I am in no doubt as to the extent of their loss and sadness. Indeed, I also know that those feelings are shared by many prisoners and the management and staff of Styal. In offering my sincere sympathies, I hope that this report may help both to explain what happened to each of the women who died and offer ways of reducing the incidence of self-inflicted deaths in the future.

Stephen Shaw
Prisons and Probation Ombudsman **October 2003**

CONTENTS

EXECUTIVE SUMMARY

1. This was an unprecedented inquiry in terms of its independence and breadth of remit. I have both investigated the circumstances of the death of a woman in HMP/HMYOI Styal in August 2003 and examined the series of self-inflicted deaths in that prison over the previous 12 months. I have endeavoured to carry out the inquiry as openly as possible and, subject to the view of the Coroner and other considerations, believe this report should be published speedily and in full.

2. The woman had a long history of drug use, offending, and imprisonment. Save for the writing of court reports, she had had no contact with the Probation Service since 1995.

3. The woman was remanded to Styal on 5 August 2003. She underwent the then standard detoxification regime of reducing doses of dihydrocodeine.

4. During the administering of medications on the evening of 12 August, a bottle of dothiepin, an anti-depressant, was stolen by a prisoner or prisoners. The woman and four other prisoners consumed the contents. The empty bottle was found and passed to staff but no action was taken save to place the bottle in a waste-bin.

5. The woman became ill less than an hour after consuming the medication. The nurse who attended believed she was suffering an epileptic seizure. It was over an hour later before an ambulance was called. By this time, the woman was bleeding and unconscious. Despite efforts to resuscitate her, the woman did not respond to treatment and by 21.55 all efforts to revive her ceased.

6. Given the quantity of dothiepin she ingested, it is by no means certain the woman would have survived whatever the circumstances.

7. Ambulances were called for the four other women who had drunk from the bottle. All were treated in hospital and discharged the next day.

8. There were significant failures in ensuring the safety and security of medications in use at HMP/HMYOI Styal. Many of these failures are now being remedied. However, the conditions in which medications are administered on Waite Wing (Styal's remand wing) are far from ideal. Further changes should be considered.

9. I make recommendations designed to improve the level of care offered to prisoners through better decision-making by staff and more effective oversight by management. I commend the actions of many staff during the night of 12/13 August. However, the Prison Service should consider if disciplinary proceedings are also justified.

10. In addition to the woman at the centre of my investigation, five other women have died at Styal since August 2002. I have identified common issues of concern including poly-drug use and detoxification, and failures in communication between medical and non-medical staff.

11. All the women who have died did so within a short period of admission to Styal, and five out six were located on Waite Wing. Both the physical environment of Waite Wing and the regimes offered to prisoners must be improved. The Prison Service should review its capital spending commitments for Styal and the Area Manager should review the design and use of the new wings already planned. The Prison Service should consider taking down the fence that separates Waite Wing from the rest of the prison.

12. Since the death of the woman, Styal has introduced a methadone detoxification programme. In principle, this should be welcomed. However, there are serious concerns about the adequacy of the resources to sustain the programme and the environment in which it is being delivered.

13. I also recommend that the role and staffing of Styal's in-patient mental health facility (the Reeman Unit) should be reviewed.

14. I have been greatly assisted by the comments of a range of interested organisations whose views I sought. I have endorsed a number of their recommendations.

15. I report upon the experience of the bereaved relatives. I make general recommendations regarding memorial services and payment for funerals as well as recommendations specific to particular families.

16. Subject to the findings at inquest, I conclude that in all six deaths the actions of the victim were the primary cause. The case of the woman at the centre of my investigation differs in that there is no reason to suppose her death was intended. The intentions of the other women can only be speculated upon.

17. What united all six women were their circumstances, in particular their drug abuse. They shared this vulnerability with many of their fellow prisoners. While the frustrations of the courts in dealing with repeat offenders are easy to comprehend, virtually everyone with whom I have spoken has argued that the current use of imprisonment for women offenders should be reduced.

18. In Styal, as in other prisons, the prompt actions of staff frequently save the lives of prisoners. This rarely comes to the attention of the public. Similarly, there is insufficient appreciation of the pressures under which staff work. However, the Prison Service owes both a legal and moral duty of care to those in its charge. During the period covered by these six deaths, there were serious inadequacies at HMP/YOI Styal in terms of regimes, facilities and procedures.

FOREWORD

This investigation was unique in two ways. It was the first time that an independent body had been called in to conduct the immediate investigation of a death in a British prison. And it was the first investigation to encompass not just one loss of life but a tragic series.

Given that the investigation had no precedent in terms of its independence or breadth of remit, I have been encouraged by the welcome it has received at all levels of the Prison Service. I should like to express my particular thanks to the Governor of Styal.

I formed a single investigative team, made up of colleagues from my office as Prisons and Probation Ombudsman and members of HM Prison Service. The combination of skills has worked well.

I have endeavoured to conduct this inquiry in as open a manner as possible. My colleagues and I have spoken with or interviewed many staff and prisoners. I have benefited from the advice of the Styal Independent Monitoring Board and HM Inspectorate of Prisons, and from the contributions of various voluntary and professional organisations concerned with penal policy. I have also solicited two independent specialist reviews.

Deleted: (?)

The report is structured in the following way. Part 1 considers the circumstances and events surrounding the death of the woman at the centre of my investigation. Part 2 asks what can be learned from the deaths of all six women at Styal to prevent a recurrence. Part 3 looks at the experience of the bereaved families. Part 4 offers some brief conclusions. There is then a list of recommendations.

PART ONE: THE CIRCUMSTANCES AND EVENTS SURROUNDING THE WOMAN'S DEATH

Section 1: The woman

The woman at the centre of my investigation was born in 1964. She grew up in Liverpool in a family of ten children. She was 39 years old when remanded to Styal prison on 5 August 2003. She was awaiting sentence on eight charges and had been separately remanded on three charges of which she was unconvicted.

The woman had two children, a son who is now 14 and a daughter of 13. I understand their father died in 1996. One of the woman's sisters cared for the children when the woman was unable to do so.

Several prisoners and members of staff whom my team and I have seen have spoken warmly of the woman. Prisoners said she was a good friend and would be sadly missed. Staff said she was likeable and someone with whom they could share a joke.

Section 2: The woman's drug dependence, her history of offences and sentences

The woman began to use heroin at the age of 18. Her history of offending dates back to 1983. Probation officers have consistently related her offences to her drug dependence. In 2002, the woman told a probation officer that the longest time she abstained from heroin was in 1990, on release from a two year sentence, when her then probation officer arranged for her to undertake a methadone reduction programme.

Between May 1983 and February 1987, the woman was given non-custodial sentences, mostly for shoplifting charges. Her first custodial sentence was in February 1987 when she was given three months imprisonment. From February 1987 to August 1998, the woman received a custodial sentence on 16 occasions. Most of that time was served at Styal. In the period between 1985 and 1995, the woman received probation orders on six occasions. Her record shows offences committed while on bail and failures to surrender to bail.

A probation officer who prepared a pre-sentence report in April 2001 said that the motivation for the woman's offences had been to fund her longstanding heroin addiction. The probation officer said there were no indications that the woman had taken steps to address her drug misuse and that her lifestyle would act as an additional destabilising influence. However, she suggested that the court give the woman an opportunity to demonstrate her intention to abstain from drugs for the sake of her children and she had reserved a place at a probation hostel. The court did not accept the proposal and imposed a prison sentence of seven months.

A probation officer who prepared a pre-sentence report in October 2002 said all the woman's offences appeared to be drug-related. The woman pleaded guilty to three charges of failing to surrender; three charges of driving without a licence, insurance or MOT; one charge of assaulting a police constable and one of resisting or obstructing a police constable; and charges of theft of £95.65, £33.97, £16.00, and making off without payment of £7.00. She was remanded to Styal. The woman told the probation officer that, before she was remanded, she was spending about £60 per day on heroin and crack cocaine but had been drug free for the three weeks of her remand. The probation officer observed that the last time the woman was subject to supervision by the Probation Service was in 1995. Subsequent sentences were for less than 12 months so there was no provision for statutory involvement by the Probation Service after release from prison.

The probation officer's assessment was that the woman's pattern of offending, coupled with her longstanding heroin misuse, meant that the likelihood of her re-offending was high unless she successfully addressed her drug problem. The probation officer commented:

> *"[The woman] would appear to have become enmeshed in a cycle of drug related offending and to date has had neither the ability nor the opportunity to take positive steps to break that cycle. Her situation appears to have been compounded by a number of distressing domestic events and a lack of stability in her life. In brief she now states that she wants her life back, both for herself and her children."*

The probation officer said she had hoped to recommend assessment for a Drug Testing and Treatment Order but could not do so because the woman could not offer a stable address. Instead she recommended a Community Rehabilitation Order with a condition that the woman attend the Addressing Substance Related Offending Programme. Accommodation was available at a registered lodgings scheme.

The court did not accept the probation officer's recommendation and imposed a prison sentence of seven months. The woman had already served time on remand and was discharged from Styal on 29 November 2002.

The woman was charged with further offences in 2003: two counts of driving whilst disqualified; one count of driving without insurance; one count of theft of £19.69 from a petrol station. She pleaded guilty and was bailed for sentencing. Sentencing was delayed. The court intended to pass sentence on 5 March 2003 but the Probation Service wrote to say that a letter had been sent to the woman offering an appointment for pre-sentence enquiries but she had not attended or been in touch to explain or fix an alternative. A further hearing was listed for 2 April but the Probation Service wrote to say that a letter to the woman arranging an appointment had been sent to the wrong address. On 17 April, the Probation Service wrote that an alternative appointment had been arranged for 8 April but a telephone message had been received saying the woman was too ill to attend. On 27 May and 12

June, the Probation Service wrote to the court to say the woman had failed to attend for interviews on 15 May and 10 June and had not provided a reason.

The woman was subsequently charged with further offences of shoplifting. She was arrested on 4 August 2003 and remanded in custody on 5 August.

Section 3: Events following the woman's arrest on 4 August 2003

The police took the woman into custody at 18:50 on 4 August 2003. The Forensic Medical Examiner's Register Form says she was fit to be detained and that the risk of self-harm was low. The entry under Advice for Custody Suite Officers says *"Heroin, Cocaine and Benzo addict without withdrawals"*. The medical examiner prescribed 2 x 5 mg diazepam and 2 x 30 mg dihydrocodeine to be given at 22:00 with an additional dose of 2 x 30 mg dihydrocodeine at 07:00 next day. However, these entries have been crossed through and an initialled handwritten note says it was alleged the woman had taken drugs in the cell so she should be woken at 30 minute intervals and her level of consciousness observed. It appears therefore that the woman was not given medication in police custody.

On 5 August, the woman was remanded to Styal. On arrival at the prison she was interviewed by a nurse, which is a routine part of the reception procedure. The form completed by the nurse recorded the name of the woman's GP and reported no history of any physical or mental health problems, except using heroin and crack, most recently the previous day, and that she smoked 20 cigarettes a day. There is no reference to the woman taking benzodiazepines. The form states that the woman did not seem excessively anxious or depressed; she did not talk of suicide and said she had never attempted suicide.

The woman was also seen by a prison doctor. There being no reference in the reception paperwork to the woman taking non-prescribed benzodiazepines, no medication was prescribed for withdrawal from these. It is not known whether the woman had been taking benzodiazepines before she was taken into custody. To alleviate withdrawal from heroin, the woman was prescribed an 11-day regime of reducing doses of dihydrocodeine. Until very recently this was the standard detoxification treatment in use at Styal for opiate withdrawal. Medication records indicate that this was administered twice a day as prescribed. Dosages were as follows:

Day	Date	Am	Pm
1	05.08.03		120mg
2	06.08.03	120mg	120mg
3	07.08.03	90mg	120mg
4	08.08.03	90mg	120mg
5	09.08.03	90mg	90mg
6	10.08.03	90mg	90mg
7	11.08.03	60mg	90mg
8	12.08.03	60mg	90mg

No other medicine was prescribed and there is no other recorded contact with healthcare staff until the day of the woman's death.

The woman was located on Waite Wing - Styal's remand wing - in cell Y1 until 8 August when she was re-located to Y2, shared accommodation already occupied by another prisoner.

In response to my invitation to offer information relevant to the investigation, a part-time tutor in the Education department said she had spoken to the woman several times. The tutor recalled that the woman had said she was withdrawing from drugs and felt unwell. Her symptoms were aching in her bones, particularly her legs, needing fresh air, and feeling cold. Initially she had sat quietly then requested to go into the Break Area, then sat by the door for fresh air, then returned to the Break Area.

An Officer Support Grade (OSG), who was on night duty on Waite Wing, recalled that, during the night of 11/12 August, the woman and her cell mate had been very loud, apparently laughing and joking between themselves and repeatedly asking for painkillers. She recalled asking them to quieten down a couple of times.

On 12 August, the probation officer who had met the woman the previous October visited her at Styal to prepare the pre-sentence report. She found the woman more positive than when she had met her before. She said she was on 'detox' but did not appear to be distressed. She was lucid and not demanding; she expressed concern about the impact of her behaviour on her children and seemed motivated to break the cycle of offending to obtain drugs. She said she would like to take naltraxone which blocks the effect of opiates. She told the probation officer that she had taken an overdose seven weeks earlier because she was *"fed up*" with the way her life was going, but that this was not an issue now.

The probation officer recorded her opinion that the woman suffered from low self-esteem and poor self-image but there was no evidence of a pattern of self-harm. The woman suggested that she got bored and on occasion acted on impulse, but the probation officer commented that her offending was well planned to meet her drug needs. In discussion, the woman recognised the rights of others but put her own drug use first. She saw the link between drug use and offending but struggled to accept that she had responsibility for change.

By contrast with the previous year, the woman would be able to live with her brother and his family. With a stable address, the probation officer intended to recommend assessment for a Drug Testing and Treatment Order. She said that, in the past, homelessness had been a factor in the woman's offending behaviour and a problem in recommending the court to take up non-custodial options.

Section 4: Events on Tuesday 12 August leading to the woman's death

Waite Wing houses remand prisoners at Styal prison. Set apart, behind a secure fence, from the Victorian villas which make up the rest of the prison, Waite Wing is a standard prison block (type DOW6) opened in 1998. It is divided into X side and Y side, each with two open landings, and a central core of offices. The Wing was originally designed to hold 128 prisoners, mainly in single cell accommodation, but it has been adapted to an Operational Capacity of 170 through the 'doubling' of many cells. It serves courts across a wide area of the North West of England and North Wales. There is a high turnover of prisoners. In addition to those on remand, Waite Wing also accommodates prisoners whose behaviour cannot be managed in the less secure environment of the houses.

All the cells on Waite Wing are unlocked for an association period from about 17:30 hours after the final meal of the day. Cells have to be locked and unlocked individually. By 20:00 all the prisoners are to be locked in their cells for the night. At 19:30 prisoners are required to collect hot water if they wish to have a drink and to go to their cells. The prisoners who work as cleaners remain out on the wing longer than everyone else to sweep the landings and the shower areas before being locked up. In practice, all prisoners are generally locked in their cells by about 19:50. Evening medications are issued through a barred gate by a nurse on each side during the evening association period.

During this period of association, Waite Wing is staffed by a minimum of one Senior Officer (SO) and eight officers, four allocated to each side. In addition, the staffing profile provides for an Officer Support Grade detailed as movements officer to be located in the centre ground floor office (the 'bubble') where the main panel for the cell call system is located. On 12 August, the OSG was redeployed to work at the prison gate and no substitute was allocated. I am told this is not unusual. On 12 August, four prison officers were scheduled to be on duty until 21:30, after the end of association. Other officers on Waite Wing were due to go off duty at 20:30. Officers on evening duty on Waite Wing are not detailed to particular tasks but are left to sort out among themselves who will supervise medications, deal with applications, settle new prisoners, etc. As one officer put it, *"we just muddle through ... we all pile in and help."* One Senior Officer, who was on duty on the evening of 12 August, told us that the Senior Officer's main task during the evening was interviewing the prisoners newly received. Interviews took place in a closed office on Y side.

Cell bell records show that the bell in the woman's cell was rung at 17:33.40. The bell was reset by a member of staff at the cell door at 17:38.44. Cell bells are rung for a variety of reasons, not always for emergencies, and it is not known why the woman or her cellmate rang the bell at that time.

Prisoners have admitted that during the issuing of medications that evening, one or more prisoners, finding the medications trolley unsupervised, reached through a barred gate and removed a 500 ml bottle of dothiepin which was on

the open bottom shelf of the trolley on Y side. The bottle was apparently hidden inside clothing, taken to the shower area and consumed there by the woman, her cellmate, and three other prisoners, probably just after 19:30. Prisoners have variously said that the bottle was removed by the woman alone, by her cellmate alone, or by the woman and her cellmate jointly. My investigators have not spoken to the woman's cellmate who has been discharged from prison and declined to arrange an appointment for interview.

The prisoner for whom the dothiepin was prescribed has estimated that she received her medication at about 19:20. Other prisoners have indicated that the bottle was taken at the end of medications at about 19:30 when prisoners were preparing to go their cells to lock up. They have said that the trolley remained at the gate behind a wooden door which was left ajar. A prisoner employed as a cleaner says that the woman at the centre of this investigation said before being locked up that she could feel the medication beginning to take effect.

After most of the prisoners had been locked up, but while the cleaners were still working, another prisoner, who was cleaning the showers on Y side level 2, removed the empty dothiepin bottle from a waste-bin and gave it to a prison officer. In her written statement, this officer estimated the time as about 19:40. The prisoner who found the bottle thought it was about 19:45. The officer who was given the bottle had joined the Prison Service only in April 2003 and she asked a more experienced colleague what to do with it.

According to the officer who was given the bottle, her more experienced colleague said words to the effect that the bottle must have been stolen but nothing could be done about it so to 'bin it'. The more experienced officer told my investigators that his recollection was that he advised his less experienced colleague to get the bottle off the landing because it was glass. He also recalled saying words to the effect that *"someone had obviously stolen it from somewhere and taken whatever was in it."* He said he was not medically trained and did not take note of what the bottle had contained. He said that with hindsight he regretted his advice and should have reported the bottle to the duty manager on the wing. At the time he was busy, the wing was *"hectic"* as usual, he was sorting things out for prisoners who were new or had returned from court, and he had not thought beyond the glass bottle being a hazard on the wing. Acting on his advice, the officer who was given the bottle placed it in a waste-bin in a staff room. Neither officer reported the find to anyone else or made any written report that evening. The officer who was given the bottle told my investigators that she wrote a statement the next day.

After disposing of the bottle, the officer went to X side to help with an incident where a prisoner, who was known to self-harm, was refusing to go back to her cell from the showers and was thought to be in possession of a piece of wire. The Senior Officer on duty that evening still had induction interviews to complete and the Evening Duty Orderly Officer came to the wing at about 20:20 and managed the incident until the Senior Officer on duty was free.

The officer who had advised about disposal of the bottle also went to X side until going off duty early, with permission, some time between 20:10 and 20:25. He had been on duty since 08:00 and was due to stay until 21:30 but, as he had missed a meal break on an escort and a member of his family had been taken into hospital that evening, he was granted time off in lieu since more than the minimum number of staff were on duty. Before being interviewed by my team, he had not been asked to prepare a written statement about what happened so, when interviewed two weeks later, he could not recall times precisely. The officer who disposed of the bottle worked mainly on X side, until leaving the prison at 21:30.

After lock-up, the woman's cellmate rang the cell bell at 20:22.30. An officer answered the call and reset the bell at the cell door at 20:23.11. The cellmate told the officer who answered the call that the woman was 'fitting' and the officer went to fetch a nurse from the treatment room which was nearby. The bell rang again at 20:24.05 and was reset at 20:24.10, then again at 20:29.31 and was reset at 20:29.33. The reason for the repeated calls is not known.

The nurse, who had administered medications on Y side, had returned from taking medications to the segregation unit which is in a separate building. He went into the cell to see the woman while the officer who had fetched him stood outside. The nurse told my investigators that he recalled that the woman was having a *"full-blown epileptic fit,"* shaking and trembling and frothing at the mouth. He put her in the recovery position and stayed with her. After about five minutes she came to and stopped shaking. He looked at her eyes and checked her pulse. Both seemed fine. He asked her cellmate if the woman had *"taken anything".* She said no. He recalled saying the cellmate should keep an eye on her and if anything else happened she should ring the bell. Asked by my investigators about the woman's condition when he left the cell, the nurse said she opened her eyes and mumbled something and looked fine. She was lying on the bed, recovered. Asked about the condition of the cellmate, the nurse said she seemed fine and quite normal.

The officer who had answered the cell bell and fetched the nurse was due off duty at 20:30. He was cleaning officer and had not expected to be involved in landing officers' work. He says that he felt left in the lurch. It was 20:35 by the time he got to the ground floor of Waite Wing. It appears other officers were all occupied with the incident on X side. He did not make any entry in the observation book to brief night staff about the woman's illness and said he assumed it was sufficient to tell the Senior Officer.

The nurse made an entry in the woman's continuous medical record which reads:

> *"Called to wing at 2020 hrs. [The woman] was having an epileptic seizure had vomited and soiled clothing, put in recovery position fitting for 5 mins, to see MO [Medical Officer] in the morning."*

The nurse and a second nurse left the wing shortly afterwards. The second nurse said she would go to the Healthcare Centre to brief the night nurse. The nurse who had visited the woman went off duty and left the prison. He was not aware of the subsequent events of the night until the Head of Healthcare telephoned, two or three days later, to say that the woman had died. He was not aware of the missing medication, and that other women had also been taken ill, until he returned to Styal to work on Sunday 17 August. He said he was not asked to prepare any written statement by the prison and had not done so.

The officer who had disposed of the bottle left X side to take fresh bedding to the woman, shortly after the nurse who had visited the woman and the officer who had advised on disposal of the bottle left. She passed the bedding through the hatch to the cellmate. She recalled that the woman was lying on one of the beds. She then returned to X side. At about 20:50 it was decided to prepare for a possible forced removal to a safer cell of the prisoner causing concern on X side. The Senior Officer on duty instructed the officer who had disposed of the bottle and others to put on protective clothing in readiness.

The woman's cellmate rang the cell bell again at 20:43.42. The call was acknowledged in the 'bubble' at 20:46.23. There was no OSG on duty in the office and it is not known by whom. When four minutes had elapsed without the bell being reset at the cell door it automatically sounded a priority call at 20:47.42. The bell was reset at 20:48.51 by an officer who spoke to the cellmate through the observation hatch.

Interviewed on 9 September, the officer who spoke to the cellmate told my investigators that she had not been asked to make a written statement so had not recorded details at the time. However, she recalled that she had been involved in an incident on X side but was no longer needed. She did not think she would have accepted the call in the office then waited before going to the cell, so she believed someone else must have accepted the call in the office. When she reached the cell, the cellmate was shouting out of the hatch that the woman was being sick and she could not move her. She said that the cellmate was not hysterical but seemed quite concerned. The woman was not responding. The cell was quite dark, probably with a night-light. The officer did not turn the main light on. She asked the cellmate whether the woman had taken anything, to which the cellmate replied no. The cellmate's speech was not slurred or abnormal. The officer told my investigators that she could not smell or see vomit, and that she told the cellmate she would call for a nurse. She was not aware that a nurse had seen the woman once already.

The officer recalled that she then reported to the Senior Officer on duty, who said that the nurses had left the wing. She telephoned the Healthcare Centre. She did not use a radio because she was not carrying one. She did not know whether it was a requirement as a late patrol officer to draw a radio. This was only her first or second day back after maternity leave and she had not worked on the Wing for 18 months. The telephone clicked into voicemail so she left a message for the night nurse that she was needed to visit the

woman. The officer believed that after leaving the message she returned to X side to help with the incident there. She remembered seeing the Night Orderly Officer on the wing and that she was probably in the office at the time. She also said that she mentioned what had happened in the evening to the OSG who was coming on duty, including – probably – that she had called the nurse. She was not aware of any of the subsequent events on Y side before leaving the prison at 21:30. When doing so, she saw an ambulance arriving but did not connect it with the woman.

The Night Orderly Officer (the most senior officer on duty overnight) had come to Waite Wing some time after 20:30 to receive the handover briefing from his evening duty counterpart, and to assist the Wing Senior Officer if necessary. The orderly officers did not make a written handover report but maintained a log in which they would record significant events. The Evening Orderly Officer said it was not unusual for women to have fits on Waite Wing and he did not make any written record of it. The orderly officer's log that evening made no reference to the incident on X side either.

A nurse arrived at the Healthcare Centre for the night shift at about 20:45. Only one nurse is on duty in the prison overnight. In a written statement, the nurse recalled that the nurse who had left Waite Wing earlier, as part of the handover briefing, had said that the woman had had a fit but the episode was over. At about 21:05, the Night Orderly Officer telephoned to say she was needed on Waite Wing X side because of an incident in which it might be necessary to use control and restraint. Two night duty patrol officers came to escort the nurse to X side. When they arrived, at about 21:10, the incident on X side appeared to be subsiding. The nurse took the opportunity to obtain the prisoner's medical notes but she was intercepted by the OSG who said she was needed on Y side to attend to the woman who was fitting.

Waite Wing is staffed overnight from 21:15 by one OSG on each side. The OSG arrived at the wing at about 20:55. She recalled that day staff had briefed her orally about a couple of matters, probably including that the woman had been sick, but not that she had previously had a fit. In accordance with her usual practice, the OSG began her shift by checking all the prisoners on Y side. At cell Y2, the woman's cellmate said she was waiting for a nurse for the woman who had been fitting. The OSG's statement says that she saw the woman lying face down on the bed. She was apparently breathing normally but her legs were twitching. The OSG says she told the cellmate she would contact the nurse but to ring the bell if the woman got any worse. As the OSG went to call a nurse, the cell bell came on. The cell bell log shows this was at 21:15.19. At 21:16.17 the switch in the office was pressed to accept the call and the bell was reset at the cell door at 21:16.26. The OSG returned to the cell, looked through the flap, saw the woman's breathing had become laboured and told the cellmate to place the woman in the recovery position. At this point it was evident the woman was bleeding from the mouth. The cellmate was shouting for the OSG to fetch a nurse.

The OSG returned to the cell with the nurse who subsequently recorded the time as approximately 21:20. On seeing the woman's condition through the hatch, the nurse called for the cell to be opened while she ran to collect medical supplies. One of the night duty patrol officers was called by radio but declined the call because she was still engaged with the incident on X side. One of the officers who was preparing to put on protective clothing on X side says he was preparing to do this when the OSG came to say he was needed on Y2 where a woman was having a fit. He went to the cell, arriving about the same time as the nurse. He opened the cell without waiting for another officer and entered with the nurse. The nurse radioed the Night Orderly Officer to call a blue light ambulance. The ambulance was called at 21:27. It is recorded as arriving at the gate at 21:35. A statement by a member of the ambulance crew says the paramedics arrived on the Wing at 21:35.

The nurse's entry in the Continuous Medical Record reads:

> *" ... [The woman] was lying on the left hand bed her head at the window end in the recovery position, her cell mate [....] was sat on her own bed facing [the woman]. [The cellmate] had her hand under [the woman]'s head, [the woman] was facing the centre of the cell. [The cellmate] took her hand out (Lt) on seeing me at the cell door and showed me blood on it saying that it was [the woman]'s blood. I could see that [the woman]'s face + extremities were pink. I could see [the woman]'s thorax moving as she breathed. [The woman] was not throwing her body around as in grand mal state but was intermittently twitching. Having no keys I asked for an officer to be called to let me in and went immediately to the treatment room which was open to bring O_2 and a mask if needed and returned to the cell at the same time as [the officer who had opened the cell]. On entering the cell [the woman] was breathing uninterrupted, but not conscious and I called for a blue light ambulance immediately. This was called for. O_2 administered and, no change to [the woman]'s condition, breathing unaided, no wheeze heard. I asked [the officer who had opened the cell] to stay with [the woman] while I got an ambu bag and airway. [The woman] began fit and twitch more rapidly, still breathing unaided but on O_2. It was established that [the woman] had been fitting for half an hour before help was called for, and that help was only called when blood was seen coming out of [the woman]'s mouth. [The woman] continued to twitch but these tremors became more violent. It was established that [the woman] had not regained consciousness. I administered 5mg of Diazepam rectally as I believed that [the woman] was in statis, asked for an update on the progress of the ambulance. I was told it was on its way and a blue light had been ordered. [The woman] became calmer but still was twitching. Her blood pressure was 130/90 pulse 205 O_2 sats 97%. [The woman]'s condition deteriorated very rapidly and although the pulse oximeter read 105 bpm I*

could find no carotid pulse. We placed [the woman] on to the floor. I replace the O_2 tubing from the face mask and put it on the ambu bag instructed [the officer who had opened the cell] when placing this in positions on [the woman]'s face to do the artificial breaths. No carotid pulse was again felt so cardiac massage at a rate of 15 compressions to 2 breaths was instigated. I completed 15 cardiac compressions and the ambulance paramedics arrived and took over. [The woman] was not responding to their treatment and all efforts ceased at 21:55."

The nurse's statement relates, in addition, that she assisted the paramedics by running to bring the prison's electric suction pump when she saw that the hand pump they were using to suck fluid from the woman's throat was not very successful.

At 23:40 the forensic medical examiner pronounced death.

The Governor contacted the woman's sister at some time between 23:50 (the Governor's estimate) and 00:20 (the sister's estimate).

Section 5: Information as to the cause of death

The provisional autopsy report says that the findings at autopsy would be consistent with a drug overdose and showed no underlying natural pathology which could have contributed to or resulted in the woman's death. In blood tests, the Forensic Toxicologist found the presence of dihydrocodeine at a concentration of 0.34 micrograms per millilitre; paracetamol at 10 micrograms per millilitre; and dothiepin at 5 micrograms per millilitre. The Toxicologist concluded that the concentration of paracetamol was within the range associated with therapeutic use and would not be expected to cause any adverse effects. The concentration of dihydrocodeine was high but within the range seen in regular tolerant users of the drug. The concentration of dothiepin was high and within the range associated with fatalities. The presence of dihydrocodeine could exacerbate the toxic depressant effects of dothiepin. The Toxicologist concluded that the findings provided strong support for the death of the woman being attributable to the effects of dothiepin, exacerbated by the presence of dihydrocodeine.

I obtained advice from the Medical Toxicology Unit of Guy's and St Thomas' NHS Trust. They told me that the blood level of dothiepin reported is very high and consistent with the features reported and the death of the woman. Typical blood concentrations following therapeutic use would be up to 0.1 mg/l. Reported cases of fatal overdose have been recorded from 0.3 to 4.1 mg/l. They have been unable to find a published report with a level as high as 5 mg/l. The speed of onset of convulsions could have been expected. The presence of dihydrocodeine would have worsened the effects of dothiepin on the woman's breathing.

The Unit supplied a note about the clinical features and management of overdose in tricyclic anti-depressants such as dothiepin. I asked whether earlier treatment of the woman might have saved her life. The Medical Toxicology Unit has advised:

> *"Speedier treatment, that is immediately after 20:20 on the 12th August, may have influenced the outcome in that it will almost always be the case that earlier treatment is better. However the amount ingested, as is indicated by the blood levels reported, was very large and it is by no means certain that [the woman] would have survived under any circumstances. Prevention of absorption (by gastric lavage or oral activated charcoal administration) would only have been recommended for 1-2 hours post ingestion. The liquid preparation in this case will have added rapid absorption."*

Section 6: Related events that night - four other women became ill

The nurse who asked for the ambulance to be called says that the woman's cellmate *"eventually"* disclosed that she and the woman had taken medicine found in the showers. The officer who opened the cell told my investigators that the cellmate said *"X"* and *"Y"* had given her the bottle and it was in the bin. He says he took the cellmate to the showers to show him but the bin had been emptied. While the nurse administered medication to the woman, the officer took the cellmate to another cell.

A night duty patrol officer stood outside the cell talking to the woman's cellmate. He recalls that the cellmate initially denied that the woman had taken anything, but then said she and the woman had found a bottle of medication in the shower area and she and two other prisoners had consumed a small amount while the woman had consumed the rest of the bottle. She denied knowing who the other prisoners were. The nurse called for a second ambulance then returned to check the cellmate's condition. According to the Orderly Officer's record a second ambulance was requested at 22:01. It arrived at the gate at 22:11 and at Waite Wing at 22:13.

The nurse said that the bottle had to be somewhere on the wing. The officer who opened the woman's cell says he went to retrieve the bin bags from the main bins outside the wing and began to empty them on to a sheet from the laundry. However, when she learned what had happened, the OSG recalled that she had noticed a bottle in the pedal bin in the movements office. This was recovered and identified. The Night Orderly Officer records in his statement that he knew by 22:00 that the liquid was dothiepin.

A night duty patrol officer prepared to accompany the woman to hospital then returned to the cell where the woman's cellmate was now located. For about 20 minutes she talked to her through the observation hatch, constantly asking her irrelevant random questions in order to monitor her level of consciousness. The cellmate said she was 'speeding' and 'twitching', then her state of consciousness began to decline very rapidly. The night duty

patrol officer called for the nurse who asked the ambulance crew who had been treating the woman to take over care of her cellmate.

The OSG proceeded to check every cell on Y side, looking through the hatch to establish that the occupant was not ill. A third prisoner was found to be on the floor of her single cell, disoriented and incoherent. Officers opened the cell. The nurse attended and one of the ambulance crews took over care. A third ambulance was requested by an officer at 22:31, called at 22:35 and arrived at 23:00.

A fourth woman was found to be lying in bed unresponsive in her single cell with a varying level of consciousness. The night duty patrol officer called for the nurse, and at 23:01 an officer requested another ambulance. Another night duty patrol officer remained outside the fourth woman's cell. The ambulance arrived at 23:40. The fourth woman told my investigator that at the time she was taking prescribed dihydrocodeine for detox but was *"rattling".* She knew she had taken dothiepin, but had taken it before and thought it would make her feel *"nice and mellow".* She expected to *"sleep it off and wake up the next day,"* but instead she slipped into unconsciousness and woke up in hospital.

The wing governor, who was the scheduled duty governor, then the prison Governor arrived at the prison shortly after 23:00 and went to Waite Wing. The prison Governor and the officer who had first opened the woman's cell asked the prisoner who had first found the bottle whether anyone else had consumed any dothiepin. She named another prisoner who might have taken some. Governors attended that prisoner's cell but she was adamant she had not taken any.

At 23:10, the woman's cellmate was taken to Wythenshawe Hospital accompanied by a night duty patrol officer and another officer who was not scheduled to be on duty but had been called in as a member of the care team to give support. The night duty patrol officer relates that the woman's cellmate's condition stabilised at 23:40 and she regained consciousness. An OSG came to the hospital to relieve the night duty patrol officer, who returned to Waite Wing at midnight to continue her night shift.

At 23:40, the third woman was taken by ambulance to Macclesfield Hospital accompanied by a prison officer and an OSG. Both remained with her until she was discharged by the hospital and returned to Styal at about 09:20 the next day. The prison officer who accompanied the third woman said he had not been present on the wing when the bottle of dothiepin was found and, when asked by the hospital staff what the third woman had taken, he was unable to tell them. The third woman says she was not given any support when she returned to the wing.

At 23:50, the fourth woman was taken to Macclesfield Hospital accompanied by another night duty patrol officer and another OSG. She was discharged at 08:15 and returned to the prison. She says the OSG told her the woman had died and both officers and prisoners comforted her. About 08:45, the night

duty patrol officer took her back to the wing then went back to reception to pick up her escort pack. Reception staff called care staff to speak to the night duty patrol officer. She left the prison at 09:15 without attending any debriefing or speaking to any managers. She was not asked to make a written statement. She was on duty again the next night and a note was left with her keys encouraging her to contact the care team.

At 00:00, another blue light ambulance was called for a fifth woman. It arrived at the prison at 00:12 and left, taking the fifth woman to Wythenshawe Hospital at 00:20. The fifth woman was 18 years old and had been in the care of the local authority. She was sharing a cell with a woman who had known her since she was a child, and whom she treated as an aunt although she was not a blood relative. The fifth woman and her cellmate say she was already feeling the effects of the medication by 19:45 when her mouth felt numb. Her cellmate knew that the woman at the centre of this investigation and others had taken medication. The fifth woman had consumed some only because she happened to be in the showers at the time. The fifth woman believed that the medication she had taken was Zispin (mirtazapine, another kind of antidepressant). She and her cellmate believed it would simply cause her to sleep heavily. Her cellmate says the fifth woman woke her in the night, holding her hand and gasping for breath. She says she went straight for the cell bell. The wing governor came running, followed by nurses two minutes later. The cell bell log shows that the bell rang at 23:43.22. It was accepted at 23:43.27 and reset at 23:44.37.

The wing governor prepared to contact the fifth woman's next of kin who was noted as her grandmother, but learning of her cellmate's close relationship with the fifth woman, she discussed with her cellmate whether to call immediately and decided to wait until morning.

The fifth woman and the second woman were discharged from Wythenshawe Hospital and returned to the prison at 15:50 pm on 13 August.

When the night duty patrol officer returned from the hospital, she decided to check every prisoner on Y side again and at first did so visually, opening the flap, putting on the nightlight and tapping the door until she saw the occupants of the cell move. She then felt this was not sufficient so went round again seeking a verbal response from every prisoner. The prisoner who had first found the bottle told her about how she found it and about handing it to an officer.

Another Senior Officer came into the prison to help on Waite Wing from about 01:00.

The wing governor and the Night Orderly Officer contacted other parties in accordance with the prison's contingency plan and, at 07:45, the wing governor conducted a 'hot debrief' attended by the Night Orderly Officer, the officer who first opened the woman's cell, one of the night duty patrol officers, the nurse who entered the first woman's cell, and the two OGS's on the wing.

Also present were the Head of Operations and the Suicide Prevention Co-ordinator.

A Principal Officer (PO) was detailed to organise a review of all open F2052SH files (for monitoring prisoners at risk) on the Wing. Notices were issued for staff and prisoners informing them of the woman's death. Precautionary F2052SH files were opened at 16:45 for the four women who had returned from hospital.

The surviving women have not been charged with misconduct under the prison disciplinary system. I am sure that is right. I understand that police investigations have not been completed.

Section 7: The theft of the bottle of dothiepin

This section considers:

- how prisoners could have gained access to the trolley
- allegations of other thefts of medication
- the reason the dothiepin bottle was on the trolley
- the use of dothiepin as opposed to safer anti-depressants
- the history of changes that have been made to the system of administering medicines at Styal
- the advice of my healthcare consultants on the system for administering medicines on Waite Wing
- practice in other women's local prisons
- action taken already to improve the safety and security of medicines at Styal.

I also draw some conclusions and make recommendations.

How was it possible for prisoners to remove the dothiepin from the trolley?

On 12 August, medications on Waite Wing were administered by two nurses, one on Y side and one on X side.

The nurses each had a trolley with a lockable lid and an open shelf below. They prepared the trolleys in the treatment room, where medications were stored in locked cupboards. They then wheeled the trolleys to the gates through which medications were dispensed.

The nurse dealing with Y side took the smaller trolley and wheeled it to just outside the treatment room. The trolley was at right angles to the gate immediately outside the treatment room, the door to which was wedged open. Also wedged open was a wooden door, hinged on the right hand side, which at other times closed behind the gate.

Neither nurse was asked to prepare a written statement after the events of 12 August. As a consequence, when they spoke to the police and my investigators, they were relying on memory of events that had not seemed

significant at the time. The Y side nurse says he did not know until he returned to work at Styal on 17 August that medicine had apparently been stolen from his trolley. The prison officer who was supervising the queue on Y side was on sick leave at the time of the investigation and has not been interviewed. However, he prepared a written statement on 10 September.

The Y side nurse is employed by another prison but is one of a 'bank' of nurses that Styal is able to call on when they are short-staffed. (Shortage of nurses is an endemic problem at Styal.) The 13:30 to 21:00 shift on 12 August was his third session at Styal. Previously, on 6 and 7 August, he had shadowed other nurses to learn the routines. This was his first session working alone. He recalls that, on one or two occasions during the administration of medicines, he left the trolley when he could not find medications. He says he had relied on there being an officer outside the gate to supervise the queue. That he left the trolley on one or more occasions has been confirmed by the officer supervising the medications queue on the X side, and by a prisoner orderly working in the staff kitchenette. The Y side nurse also recalls finding the dothiepin bottle on the open shelf of the trolley rather than in the lockable top cabinet.

The X side nurse recalls the Y side nurse calling to ask her if she had particular medications that he needed and that on occasion he went to get products from the treatment room. From where she was positioned, the X side nurse could not see whether an officer was outside the gate on Y side at the time.

The Y side nurse is critical of the physical location in which he was required to administer medications at Styal which he considers cramped and unsafe. Prisoners came near the gate and he says it would not have been difficult to reach a hand through and take something. He compares the system unfavourably with the arrangements at the main Healthcare Centre at Styal and at the other prison where he worked where individualised medicines are passed through a hatch.

In his written statement, the prison officer who supervised the Y side queue says that medications began at about 18:35 and he controlled the queue so that only one prisoner could approach at a time. The women waiting in the queue were about 12 feet away. He says that, at about 19:00, he heard aggressive shouting from the ground floor on Y side. He says he told the nurse to stop the medications while he investigated and left the gate for about half a minute. He then returned and continued the medications with the nurse. This was still going on when, at about 19:30, another prison officer called for prisoners on Y side to return to their cells. The officer supervising the queue estimates that medications were completed by 19:45. He then checked the metal gate, told the nurse he would go and help his colleagues with locking-up and went to the ground floor to do so. He says that when he left the pharmacy gate there were no prisoners in the immediate area. He was unaware of any problems before leaving the wing at about 20:20 to go off duty at 20:30.

In an interview on 29 August, another prison officer described an incident on Y side level 1 involving two prisoners, one of whom was unwilling to vacate a 'first night' cell. This may be the incident the officer supervising the queue is referring to, although the other officer places it later than 19:00 because she recalled that it occurred when they were starting to lock up for the night at 19:30. She said that she remembered that there were still women milling about at 19:40 - which was partly why she was conscious of the need to remove the glass bottle from the landing since it might be a hazard or a weapon.

There is no audit of medications after the evening session and the dothiepin was not missed. (I understand from the Deputy Head of Healthcare in HM Inspectorate of Prisons that it is not usual practice for medications to be audited after treatments, except in the case of controlled drugs.) The pharmacy technician maintains stock control mainly to ensure there are adequate supplies.

Other alleged thefts of drugs

Prisoners and staff have both told my investigators that unauthorised medications circulated on Waite Wing, principally through women being pressured by others to hand over their prescribed drugs. We were also told that medications had on occasions been removed from the medications trolley before 12 August. These claims were made mainly by prisoners. One said dihydrocodeine and Valium had gone missing on three occasions; another that she was offered tablets on the first Saturday that medications were administered during association; another that she was offered tablets on Saturday 9 August; another that "a few" bottles of Valium had been taken from the trolley. A similar allegation has been made to HM Inspectorate of Prisons by a former Styal prisoner.

The Acting Detoxification Manager told my investigators she was aware of a rumour that Y side prisoners had taken a box of diazepam (Valium) from the trolley before 12 August. A new staff nurse had left her trolley unlocked while she took some tablets to X side. The Head of Healthcare said that the nurse was spoken to by her line manager and the Governor was informed.

A security information report referred to information received from a prisoner on 13 August that Valium had been taken from a Wing trolley a few days previously. The prisoner informant said she had been told it was very easy to steal from the trolley when a particular (female) nurse was on duty.

The bottle of dothiepin

The bottle contained dothiepin in a concentration of 75 mg/5ml. The prisoner for whom liquid dothiepin was prescribed has confirmed that she received her dose that evening. She says that the Y side nurse was initially unable to find the bottle, which was on the open shelf below the lockable part of the trolley. The prisoner estimates that she received her medication about 19:20. She had been prescribed a single daily dose of 75mg dothiepin in tablet form. She

told my investigators that, after a couple of days, she asked the nurses whether she could be put on liquid medicine because there were women who badgered other prisoners for medication. She recalled that she had had two or three doses from the 500 ml bottle by 12 August.

The Medical Toxicology Unit of Guy's and St Thomas' NHS Trust have commented on the large quantity of dothiepin that the bottle apparently contained. They advise that 7,500mg is sufficient for a fatal dose to have been taken and for there to be enough left to produce milder effects in others.

The bottle had been supplied for another prisoner whose name had been scored out on the label. The pharmacist is unable to identify which prisoner, so it is not known how much of the medication had been used.

The Area Health Care Advisor for Women's Prisons says that, in his view, the transfer of medication back to stock is not best practice and it would have been preferable for the medicine to have been re-ordered either in the new prisoner's name or as a stock item.

The Head of Healthcare explained what had happened. Liquid rather than tablet form dothiepin was required but Styal's then pharmaceuticals supplier (HMP Risley) said it would be days or possibly weeks before they could provide it. A nurse consulted Styal's pharmacist who agreed that an existing bottle, dispensed for a woman who had left the prison, could be changed to a 'stock' bottle from which dothiepin could be administered. The Head of Healthcare's view was that this was not best practice. But she had been advised by the National Director of Nursing that it was considered safe and acceptable, and in the circumstances in the best interests of the patient. The more frequently used medications were commonly administered from 'stock', especially on Waite Wing, where more than 100 women were on medication. The alternative might be, for example, to have 60 bottles of Diazepam of varying doses. There was simply not room for 60 different bottles.

Two members of staff from Mersey Care NHS Trust, have also advised me on healthcare matters. They observed that medication on Waite Wing is primarily administered from stock with only a small number of pharmaceutical items individualised. Like the Area Health Care Advisor for Women's Prisons, they consider prescription on an individual basis to be preferable, while recognising that, on occasions, stock items are retained for the benefit of patients. Their view is that it is *"absolutely imperative"* that stock items should be audited at the beginning and end of the administration process.

The use of dothiepin

Dothiepin is a tricyclic anti-depressant and is particularly lethal in overdose. In December 2001, the Primary Care Group of East Cheshire NHS Trust issued an addendum to advice on the treatment of depression to the effect that it was no longer recommended as a first line anti-depressant because of possible adverse effects on patients with heart problems. The Area Health Care Advisor for Women's Prisons told my investigators that, on 19 August,

12 women on the Wing were prescribed tricyclic anti-depressants and 24 the safer Selective Serotonin Re-uptake Inhibitors (SSRIs) which he advises are equally effective with fewer side effects and much less dangerous in overdose. In the houses at Styal, however, of 82 prisoners on anti-depressants, 38 were on SSRIs and 44 on the older tricyclics.

The medical officer working at the prison under a contract with FMS Primecare said that, unlike SSRIs, tricyclic anti-depressants had a sedative effect. He would sometimes prescribe them for that reason rather than giving long term sleeping medication. Women withdrawing from drugs often suffered from insomnia and therefore expressed a preference for tricyclics, although the contracted medical officer considered that insomnia was exacerbated by enforced inactivity during the day when many prisoners were locked in their cells. He encouraged women to attend the gym whenever possible, and considered that greater physical activity was a preferable alternative to chemical sedation. He was not aware of the PCT advice but said he had concluded on his own initiative that it would be desirable to switch to SSRIs.

The contracted medical officer said he knew that women at Styal had nicknamed him 'Dr No'. He said that did not mean that he did not prescribe medication he considered appropriate. He was the only full-time doctor working at Styal and had worked in the Prison Service for 16 years. FMS Primecare sent other doctors when he was off duty. At present there were four who did sessions at Styal. The contracted medical officer had no line management responsibility for them and monthly meetings that used to take place with the other doctors and the company had fallen into abeyance. He said that he felt prisoners were sometimes able to take inexperienced doctors for a ride.

The Prison Service has instigated a review of the prescribing of dothiepin in prisons. The Medical Director of Prison Health says that the results are for individual prisons to consider at their Drugs and Therapeutics Committee, but Prison Health will assess the clinical data in aggregate. The Health Care Advisor for Women's Prisons' view is that the old tricyclic drugs should no longer be prescribed unless there are strong indications that other drugs are not producing a positive response. Although many prisoners are already taking tricyclics prescribed by their GPs, there are protocols available to 'stop and swap' to use the more modern treatments. The Medical Director of Prison Health is sympathetic to that view, but comments that prescribing dothiepin is not of itself bad practice and every patient's clinical needs must be considered individually.

Changes to the system of administering medicines on Waite Wing

The system of administering medications on Waite Wing has been changed twice in the last 12 months. The changes have been contentious.

Until August 2002, medications were issued broadly as now, through the barred gates on level 2 on each side. At that time, however, the arrangements for association were different so there were generally fewer

women out on the wing. After the death of another woman on the morning of 10 August 2002, the wing was locked down while staff dealt with the impact of her death. Nurses were asked to take the medications trolley round to cell doors. The Acting Detoxification Manager observed advantages to the system: nurses were able to administer medications in greater calm and privacy; women were less vulnerable to coercion to hand over medication to others; nurses were better able to ensure women consumed medicine and did not secrete it. Administration of medicines at the cell door was then introduced as routine, initially as a pilot which the Head of Healthcare says confirmed that there had been a reduction in the secretion of medicine and bullying. A protocol was issued on 17 September 2002 specifying that all nurses must have the trolley keys in their possession, and never leave the trolley unattended but withdraw to the sterile area and lock the trolley in the event of administration being interrupted. The Head of Healthcare stressed that it is a basic tenet of nurses' professional practice that they are responsible for the security of drugs in their charge.

The disadvantage of this method of administering medications was that it froze movements on the wing. The series of deaths of women on Waite Wing gave rise to mounting concern about the nature of the regime and its capacity to support intensely vulnerable women. In June 2003, a new Deputy Governor and the Wing governor were appointed with a brief to improve the regime and lifestyle of the women at Styal. They published an initial evaluation on 17 July 2003.

The Deputy Governor told my investigators that they had found that prisoners on Waite Wing were spending very little time out of cells and he felt that every movement on the wing was over-controlled. Locking women up was the main way of exercising control. Only one landing on each side was opened for association at a time. If the first landing was delayed, the second landing would get less time. Staff were spending most of their time locking and unlocking doors. In the short periods that women were out on the wing, there was a *"frenetic mêlée"* because the women had only half an hour or less to get everything done – to have a shower, make telephone calls, have their questions answered and so on.

The Deputy and Wing Governors concluded, in particular, that the administration of medicines was being allowed to govern the wing. In the morning, nothing happened until the medication trolley had gone round. It never finished before 09:00 and prisoners often missed the opportunity to go to work or education because movements were frozen during roll-check, which happened at a set time whether Waite Wing was ready or not.

At the end of July, it was decided that all the women on Waite Wing would have association at the same time after the evening meal and that, to facilitate this, the system of giving out medicines at the barred gate would be restored. The same system would be used in the morning. The Deputy Governor said he was aware there was resistance to the changes among staff who were comfortable with what they saw as a safe way of working and who lacked experience of alternatives. The Wing governor issued two notices to staff.

The first announced the changes to association and medication that were to take place from Monday 24 July. The second, in response to concern expressed by staff about the risk of bullying for medications, instructed staff to ensure that no prisoner, other than the one receiving medication, should be allowed to enter a marked area on the floor outside the medications gate.

The Waite Wing governor says he discussed the changes with POs and SOs though not at a particular meeting. No risk assessment was conducted before the changes were implemented. He recalls that consideration was being given to risk assessment, but the concern was that the nurses might need protection, not that medicines might be stolen. The Waite Wing governor and others stress that the change to the medications system involved reverting to a previous system not introducing something new. His assessment was that the resistance was mainly to having increased numbers of women out on the wing rather than to changing medications.

Immediately after 12 August, a perspex screen was installed at the barred gate where medications are administered. The Head of Healthcare said that this had originally been commissioned more than a year earlier - along with other security works - as part of a safe system of working for the administration of methadone. The full detoxification regime had not been implemented and the works had not been done. The Head of Healthcare assumed they had not been considered urgent. Staff told us that the perspex ought to have been in place when medications at the gate resumed but it was delayed because a carpenter was sick.

The screen was intended to protect nurses from abuse rather than to prevent access to the trolley. But if it had been in place on 12 August, prisoners would not have been able to take the dothiepin bottle.

The Acting Detoxification Manager said she believed there had been an increase in secretion of medicines and bullying since they stopped administering medications at cell doors. More women seemed fearful or were asking for medication in liquid form. She thought that the impact on Waite Wing of giving medicine at the cell had been exaggerated. In June 2003, she had arranged for most of the Wing medications to be administered twice a day instead of three times a day, so the women would be able to pursue activities during the day. But nothing changed. There were few opportunities for purposeful activity and most of the women remained locked up most of the time.

Nine nurses who were not directly involved in the events of 12 August responded to my invitation to contribute to the investigation. Feelings were clearly running high, not least because of a desperate shortage of permanent nursing staff. The prison needed 30 nursing staff and had just 18. The concerns expressed included feeling threatened and vulnerable on Waite Wing, and a sense that nursing staff were not consulted. As a consequence, decisions were made by non-healthcare staff that some nurses felt might put their professional registration at risk. On the whole, the nurses did not single out Waite Wing medications above other concerns.

The advice of my healthcare consultants on the system for administering medicines on the Wing

I note here healthcare consultants' observations that:

- The cramped conditions in which the nurses administer drugs and the close proximity of the trolley to the gate had the potential to allow unauthorised access to the trolley, in particular to the bottom shelf which is open on all sides.

- The environment of Waite Wing is not conducive to allowing a single nurse to administer medication to a large number of people.

- The nurse administering medicines on Y side was working in the most extreme of conditions. Given an environment more conducive to the care of women with many varying types of health needs, he might have thought to return the bottle to the treatment room where the stock items are kept in locked cupboards.

- Communication between health and discipline staff appears to be minimal. Staff said that they found it difficult to discuss prisoners' needs because of the amount of activity and lack of staff.

- The healthcare staff interviewed are dedicated, working in the most challenging of environments and circumstances, and want to work with prison officer colleagues to improve the situation for the women on the wing. They are a resource that needs to be utilised and included in the management of change across the prison.

The consultants also noted that the perspex screen prevents access, but at times it occludes the nurses' view so that they cannot observe the ingestion of medicine. Nurses reported that it was very difficult to hear what the women awaiting their medication were saying. The Area Healthcare Adviser recommended that holes be drilled in the screen and a wooden batten that impeded the nurse's view be removed. This has now been done but I do not know whether it entirely removes the problems.

Among other things, the consultants recommend:

- The development of policies and procedures for the safe and secure handling of medicines with training to support staff during the implementation process.

- Those policies and procedures should be underpinned by robust systems for risk assessment, which should include the reporting, recording, audit and monitoring of untoward occurrences and adverse incidents.

Practice in other women's local prisons.

A member of my investigation team prepared a report on methods employed to administer medications in other local prisons for women. In summary, my investigator found:

- At Brockhill, medications are administered through a hatch described as similar to a bank counter. The nurses stand behind a glass panel and may have to shout to make themselves heard. Two officers assist: one next to the hatch, one monitoring the queue.

- At Eastwood Park, medications are administered at a healthcare room, with prisoners attending wing by wing. The nurse administering the medications stands behind a grille with the top half of a 'stable-door' open. One officer and one healthcare officer or nurse attend outside the healthcare room.

- At Holloway, most medications are at present administered at the cell door during lock-up three times a day. It is hoped to move to an increase in medication in possession and that the remainder will then be administered at a healthcare room. It has yet to be decided whether this will be through a gate, door or hatch.

- At Low Newton, medications are administered through an unscreened hatch at a treatment room in the main prison. Two officers attend outside the hatch.

- At New Hall, in the main prison and the detoxification unit, medications are administered from a treatment room through a hatch surrounded by transparent material. There is not always an officer present when medications are administered on E wing and F wing. In the detoxification unit, an officer supervises the queue. Medications are kept in locked cupboards away from the hatch.

- In the main prison at Styal, medicines are administered from the healthcare room through an unscreened grille. The nurse and the trolley are distanced from the grille by a work surface. One officer supervises the queue. During the summer months, the women have queued out of doors and only entered the healthcare building two at a time, one to receive and one to wait. I was told, anecdotally, that fewer women turn up when the weather is cold or wet. That causes me concern.

This comparison indicates that, until the perspex screen was installed, the arrangement on Waite Wing provided a less protected environment than in any other prison. Except at New Hall, the nurse is supported by two other members of staff. Except at Holloway, where medication is given at the cell door, nurses have the benefit of a hatch or at least a 'stable-door'.

The extent of medication issued in-possession varies from prison to prison. The Department of Health/HM Prison Service report, *A Pharmacy Service for*

Prisoners (June 2003), advocates a policy of allowing greater quantities of safer medications to be held in possession. The benefits of in-possession medication are several and attractive. It reduces the number of prisoners attending each administration of medication and the number of public interactions between patient and professional. It allows the prisoner to retain responsibility for his or her own wellbeing. And it frees prisoners from spending their association time waiting for medications.

However, in-possession medication depends in most cases on an individual risk assessment of each prisoner. Where the prisoner population is constantly changing and a large proportion has acute dependencies (for example, in Waite Wing at Styal), the scope for in-possession medication may be more limited. Even where in-possession medication is extensive, healthcare professionals have told me of instances where prisoners take medication inappropriately or opt out of the scheme due to bullying.

Where in-possession medication can be administered appropriately, held safely, and protected from abuse by the patient and other prisoners, its benefits are manifest. However, it is regrettable that *A Pharmacy Service for Prisoners* has nothing to say about arrangements for administering medicines nor about the special medical needs of women prisoners, especially those first entering prison.

Action taken already to improve the safety and security of medicines at Styal

I am aware that Styal took immediate steps to try to ensure that an incident like that on 12 August could not occur again. The perspex screen is the most obvious measure but in addition an action plan has been drawn up in conjunction with Prison Health and the North West Prison Health Development Team. The action plan deals with immediate issues of security of medications, the preparation and dissemination of new policies and protocols, arrangements for pharmacy stock control and dispensing, prescribing practice in relation to SSRIs, and also broader questions about the provision of healthcare services at Styal.

Conclusions and recommendations relating to the theft of dothiepin.

Among other things, my consultants recommend that further consideration needs to be given to the administration of medicines on the Wing and a thorough risk assessment to ensure a safe system of working. I agree and I welcome the work that has already begun. I am, however, concerned that no fresh risk assessment took place before the Wing reverted to administering medications at the gate. Although I have been told that the arrangements were not ‘new’ but the restoration of a previous system, it seems to me that the increased number of women on evening association was a new factor that ought to have been considered.

The Prison Service has taken immediate steps to respond to the deficiencies so tragically demonstrated on 12 August. I think that practitioners are best placed to devise the appropriate detailed measures.

I recommend:

The Governor and Head of Healthcare in conjunction with senior representatives of the North West Prison Health Development Team and Prison Health should consider this report, including the advice from my consultants, and review whether there are other practical measures that should be added to the action plan.

The installation of the perspex screen since 12 August has now increased security, both of the nurses and of the medications. I remain of the view, however, that the conditions in which medications are administered are far from ideal.

It may be that what are needed are changes to the physical environment – say, by providing a proper waiting area in Waite Wing or elsewhere. It may be too that there must be a culture shift – to see the issuing of medications not as an encumbrance to the regime but as a core aspect of the regime. It could well be argued that, in their first days and weeks in custody, attending to women's detoxification and other medical needs is far and away the most important thing the Prison Service can deliver

I understand that the design and structure of Waite Wing makes it difficult to make alterations to the fabric but I recommend:

The Governor and Area Manager should consider whether changes can be made to Waite Wing to provide an environment for the administration of medication that:

- **permits effective communication between nurse and patient that is out of the hearing, and preferably out of the sight, of other prisoners;**
- **facilitates communication and co-operation between nurses and officers;**
- **allows nurses to observe the ingestion of medication;**
- **and ensures that medicine supplies are out of reach of patients.**

In addition, I recommend:

Whilst taking note of the consultants' observations about the unsatisfactory environment in which the nurse administering Y side medicines was working, the Prison Service should take advice from the Nursing and Midwifery Council about the loss of the bottle of dothiepin from a nurse's trolley and consider whether any other action is necessary.

Section 8: Other critical issues raised by the incident

This section considers the following other critical issues arising from the events of 12 August:

- Why did the closed circuit television cameras fail to record the theft of dothiepin?
- Why did staff not realise the significance of the empty bottle*?*
- Was the nursing care given to the woman at 20:20 adequate and appropriate?
- Were handover arrangements adequate at change of shifts?
- Was there avoidable delay in providing care after the woman's cellmate rang the cell bell again at 20:43?
- Was the nursing care given to the woman from 21:15 adequate and appropriate?
- Was the prison's response appropriate once it was known that women in addition to the woman at the centre of this investigation had taken unauthorised dothiepin?

Closed circuit television system

Waite Wing is equipped with video monitoring equipment which makes a continuous recording of events on the wing by means of 16 cameras. The purpose of the system is to provide evidence in the case of a contentious incident. However, Waite Wing staff told my investigators they had not been trained to use the equipment. None of the cameras was directed at the medications gate and, on 13 August, it was found that the cameras had been turned off shortly before the incident. It appears that this was inadvertent and it is not known who was responsible.

Evidence from the supplier of the system indicates that the system had been regularly switched off in an inappropriate manner leading to corruption of the hard disk. Works staff say that, when the system was installed, an instructor from the manufacturers ran two training sessions for staff. However, this was less beneficial than hoped for because of staff being taken from training for other duties and a general lack of interest in the system.

On 21 August 2003, further training sessions were held for seven staff but cut short by a POA meeting. The Senior Officer on duty on the evening of 12 August 2003 told my investigators the training was unsatisfactory. It took place in the small movements office, where the system is sited. But as this is the hub of the wing, with two telephones and the wing computer terminal, the training was constantly disrupted by other activities. The Senior Officer also said that attempts since 12 August to redirect a camera to cover the medications gate had not been successful.

It appears that there are no policies or protocols for the use and maintenance of CCTV systems installed at Styal, nor for the logging and retention of recorded information. Management ownership is not clear.

I recommend:

> **The Governor of Styal should review the use of the electronic monitoring equipment installed throughout the establishment to ensure that responsible staff understand the system and are able to use it efficiently for its intended purpose.**

Why did staff not realise the significance of the empty bottle?

The dothiepin was consumed just after 19:30. The empty dothiepin bottle was handed to staff by about 19:45.

The failure of staff to recognise the significance of an empty medication bottle in the prisoners' showers area was an error of judgement that may have had grave consequences. Nursing staff told my investigators that, if they had known that the woman might have taken unauthorised dothiepin, they would have called an emergency ambulance as soon as she became ill. Wing and healthcare staff would doubtless have worked together - as they did after 21:00 hours - to safeguard the health of the other women too.

I have no doubt that both the staff concerned profoundly regret their actions. One of the staff concerned was a very new officer. The other had been in the service nearly four years, all at Styal.

I recommend:

> **The Governor of Styal should examine whether the failure by two members of staff to report the finding of the bottle indicates shortcomings in induction, refresher and security training and in management.**
>
> **The Prison Service will also wish to consider whether the incident should be the subject of a disciplinary enquiry.**

Was the nursing care given to the woman at 20:20 adequate and appropriate?

In evaluating the nursing care given to the woman, I rely on the advice of my clinical advisers.

The Area Healthcare Advisor says that the woman's symptoms at 20:20, as described in her medical record, could have been symptomatic of an overdose of a tricyclic antidepressant or of acute withdrawal from heroin, crack and benzodiazepines, which was not being adequately controlled by her detoxification regime. He says that he would have expected further intervention and medical advice to be sought.

From their enquiries at Styal, my clinical advisers say it appeared to be commonplace not to call a doctor to a patient following a first fit when a doctor was not in the prison, even when a patient had no previous history of fitting or a condition that might cause fitting. The nurse who administered medications on Y side considered he was following an unwritten procedure.

The consultants comment:

> *"This is a particularly difficult call and can be confusing when working and caring for patients who are undergoing detoxification, as it is not uncommon for these people to fit."*

They note, however, that there appeared to be no protocols in place to advise on appropriate clinical care for a patient who is fitting.

In the consultants' view, the nurse's assessment was a *"high risk decision,"* given his description of the extent of the fit and the absence of any known relevant history. They consider that the appropriate action would have been for the nurse to take adequate, timely and regular observations of the woman's condition and to have ensured that these observations were to be continued and reviewed by the night nurse coming on duty.

The consultants conclude:

- that there is an over-reliance on the individual nurse practitioner to understand the complex and intricate healthcare needs of a patient on a detoxification programme;

- that there is a lack of supportive procedures or guidelines for the management of the fitting person in place for healthcare staff or prison officers and that this should be rectified urgently.

The consultants also note that it appears to be commonplace for a cellmate to be asked to call for assistance when a prisoner is unwell. Delegating vigilance to a cellmate raises difficult issues that the Prison Service might wish to reflect on.

I recommend:

> **The Governor, Head of Healthcare, the Healthcare Adviser for Women's Prisons and Prison Health should take note of my consultants' observations and consider what measures need to be taken to inform and support nurses in the care for patients during detoxification.**
>
> **In conjunction with Prison Health, the Prison Service should consider the extent to which a prison can meet its duty of care by relying on a cellmate to raise the alarm.**

Again whilst taking note of the consultants' observations, the Prison Service should take advice from the Nursing and Midwifery Council on the nursing care provided to the woman at 20:20 hours on 12 August and consider whether any other action is necessary.

Was there avoidable delay in providing care after the woman's cellmate rang the cell bell again at 20:43?

The nurse who administered medications on Y side left the woman in the care of her cellmate, asking the cellmate to keep an eye on her and saying that, if anything else happened, she should ring the bell. The cellmate did so at 20:43. I have not been able to establish that any member of staff remained on Y side or in the 'bubble' at that point. It seems that the incident on X side was allowed to occupy all the available staff on the wing with no one left to cover Y side. Over five minutes elapsed before the call was answered at the cell. The cell bell call log shows that it is unusual for calls not to be answered within four minutes (when the audible signal goes into priority mode) and they are usually answered much earlier.

The cellmate was shouting that the woman was being sick and she could not move her. The officer who answered the call looked through the hatch into a dim room with only a nightlight. The woman did not respond or move. The officer could not smell or see vomit. She was not aware that the woman had fitted earlier. The officer spoke to the Senior Officer on duty who was engaged in the X side incident, and who told him the evening nurses had left the wing.

The officer relied on a voicemail message left on a telephone in the Healthcare Centre to summon a nurse to the woman. She did not use the radio net and the Orderly Officer was not informed that a nurse was required. Healthcare staff told me the voicemail system was for administrative communications. They would not expect it to be used to summon a nurse.

The officer believes she may have mentioned to one of the OSGs that she had called for a nurse. That there was an urgent need for a nurse came to the OSG's attention only as a result of her own round just before 21:15. By then it was some half an hour since the cellmate had rung the cell bell, and since the officer who answered the call became aware that the woman was inert and not responding.

I recommend:

The Governor of Styal should examine whether the failure to ensure that a nurse was called promptly indicates shortcomings in training, management and guidance to prison staff on the action to be taken by prison staff when women are ill.

The Prison Service will also wish to consider whether the failure to ensure the timely attendance of a nurse should be the subject of a disciplinary enquiry.

Were handover arrangements adequate at change of shifts?

The woman's condition deteriorated during the time when evening duty staff were handing over to their night duty colleagues. The practice was for discipline and healthcare staff each to brief their night duty counterparts.

When asked what he would have done if the woman had fitted again, the nurse who had administered medications on Y side told the consultants, *"I'd be on the phone like lightning."* But no such sense of urgency was imparted either to the discipline staff on Waite Wing who were preoccupied with another potentially life-threatening incident on X side, or to the night nurse, who was told only that the woman had had a fit and the episode was over.

The purpose of handover arrangements is to ensure continuity of care. Manifestly, they failed in this case.

I recommend:

The Governor of Styal should review handover arrangements at change of shift with special attention for the need for discipline staff to be aware of any health concerns.

There is reason to believe that a haphazard approach to briefing colleagues at change of shift may be reflected in under-reporting of incidents generally. The investigation team examined entries in the Incident Reporting System from 1 January 2003 to 31 August 2003. There was evidence to suggest that there have been many occasions when self harm incidents have gone unreported. The Suicide Awareness Co-ordinator has confirmed this. He states that in August 2003 only 15 F213SH (self harm returns) were completed which he estimates to be *"massive under-reporting"*.

The level of detail of entries was not always satisfactory, sometimes omitting time, date and place of the incident as well as a concise description of what took place, as required under Prison Service Order 1400. The entry for the events of 12 August did not include the names of the women taken to hospital.

Many staff told the investigating team of near misses where staff have undoubtedly saved lives. But these incidents too seem to be subject to under-reporting. Not all staff were aware of incident reporting procedures. Some who were stated that the pressure of work prevented them from completing these tasks. None of this is helped by the fact that medical staff only record information in the individual's IMR (inmate medical record) and appear to have no input into incident reports.

Here is another example. During interview, many staff mentioned that 'de-crutching' is a regular occurrence on Waite Wing, whereby prisoners check forcibly if a prisoner has secreted drugs internally and, if found, remove them. Yet of the five assaults reported on IRS for the period I have examined, there is only one sexual assault. (This type of assault is regarded as especially serious and is required to be reported to the Prison Service National Operations Unit as well as being put on the reporting system.)

There also appears to be little written evidence of incidents in the Orderly Officers' Observation book. We were led to believe that the Duty Governor checks the Orderly Officers' book on a daily basis, but never identifies shortfalls in reporting.

I am aware that many staff at Styal perceive themselves to be 'firefighting' from one crisis to the next. Indeed, this is frequently the reality. I also do not underestimate the impact that the series of deaths at Styal has had on staff morale and self-confidence. One member of staff expressed a condition described by many:

> *"You're just relieved to go home at the end of the day and no one's died."*

Nonetheless, systematic reporting of serious incidents is essential if lessons are to be learned, risks evaluated and resources applied appropriately.

I recommend:

> **The Governor of Styal should review incident reporting procedures in the prison.**

Was the nursing care given to the woman from 21:15 adequate and appropriate?

Again I rely on clinical advisers, but their assessment has confirmed the favourable layman's impression I had formed. I quote the consultants:

> *"Having interviewed [the nurse who called for help for the woman] and following our observations we feel we should comment on the actions taken by her. We consider her to have taken prompt and accurate action. We believe she behaved in a professional manner that befits her position and registration with the Nursing and Midwifery Council."*

I recommend:

> **That the Governor of Styal write to the nurse who called for help for the woman to tell her of the consultants' warm remarks about her conduct on the night of 12 August.**

Was the prison's response appropriate once it was known that women in addition to the woman at the centre of this investigation had taken unauthorised dothiepin?

From the evidence gathered by my investigators, I conclude that the prison staff on night duty worked together admirably, with initiative and with care, in the most shocking of circumstances. Unlike their colleagues on the evening duty, they had the benefit of knowing the nature of the catastrophe they were dealing with. But I have no doubt that their actions prevented yet greater tragedy. I particularly note the distressing experiences endured by OSGs and basic grade officers, some young in service, who carried on without respite throughout the night.

Whilst not detracting from the burden shouldered by governors, I particularly commend the off-duty uniformed staff who came into the prison to support their colleagues.

I recommend:

> **At the next convenient opportunity, the Governor of Styal should draw the attention of all staff to my commendation of those on duty on the night of 12 August. I hope she will also consider if individual staff should be acknowledged through the Prison Service's Performance Recognition Scheme.**

PART 2: WHAT CAN BE LEARNED FROM THE DEATHS OF WOMEN AT STYAL TO PREVENT A RECURRENCE?

Section 1: The series of self inflicted deaths of prisoners at Styal since 10 August 2002

In addition to the death of the woman at the centre of this investigation, five other prisoners have died at Styal since August 2002:

Ms A on 10 August 2002
Ms B on 26 November 2002
Ms C on 18 January 2003
Ms D on 20 April 2003
Ms E on 4 June 2003

The inquest on Ms A has just taken place (October 2003), 14 months after her death. Those on the other women are still pending. The Prison Service investigations into three of the other deaths are also incomplete. For these reasons, my comments on the circumstances of the deaths must necessarily be provisional.

I have drawn a good deal on what I have been told by the relatives of each of the women. However, in practice, my involvement with the next of kin has differed in each case. I have tried as far as possible to meet their wishes in terms of the form that contact has taken. That said, I am very conscious that other family members have not been contacted directly. I know that many police forces now employ specialist staff to liaise with bereaved families, and am aware of the project which Safer Custody Group is running to develop a 'toolkit' for family liaison officers in the Prison Service following a death in custody. Were the responsibility of investigating all deaths in prison custody to be passed to the Ombudsman's office (a proposal on which the Government is currently consulting), I should wish to include such specialists amongst my team.

Ms A

Ms A was aged 20 and had one child. Ms A died by ligature, apparently made from curtain material, applied between 06:45 and 07:50 on Saturday 10 August 2002, two days after her admission to Styal. Ms A was in a cell on Waite Wing shared with a prisoner on an open 2052SH (considered at risk of suicide or self-harm).

Ms A was on remand for breach of a Community Rehabilitation Order, a sentence received for possession of heroin and cocaine and handling stolen goods. She arrived in Styal from court on Thursday 8 August 2002, after being 'locked out' of Brockhill (where Ms A had spent time on remand in February 2002) because it was full.

The investigation report on Ms A's death refers to admission procedures being rushed. The prisoner escort form showed Ms A as having drug and alcohol problems and a past history of suicide and self-harm. Ms A appears to have said she was not feeling suicidal and was not placed on a 2052SH on admission.

At reception, Ms A said she was withdrawing from crack and heroin but she was not displaying symptoms and was assessed as not requiring medication to assist detoxification. The toxicology report after Ms A's death showed the presence of opiates that could have been taken any time from 12 hours to three to four days before her death.

Like the parents of many drug-abusing children, Ms A's parents had wrestled with the dilemmas of supporting their daughter while not funding or endorsing her life-style. Ms A's parents trace their daughter's misfortunes to a miscarriage she suffered after the birth of her daughter. They believe their daughter was happy at Brockhill but anxious about being sent to Styal. They wonder if their daughter intended a 'cry for help', not realising that she would be unlocked an hour later at the weekend. An open verdict was recorded at the inquest.

Ms B

Ms B was 29. She died by ligature, apparently made from strips of towel, applied between 12:00 and 13:50 on Tuesday 26 November 2002. She had been in Styal on remand for 25 days.

Ms B had drug-related convictions dating back to 1989 (when she was 16). This was her first spell in prison. She had a long-term partner, who was her co-defendant. Ms B's behaviour was said to be volatile and she was on an open 2052SH throughout her time at Styal. On 7 November, she was moved to a safer cell for one day following a report by her cellmate that Ms B had attempted to hang herself. Otherwise, Ms B was in a shared cell until the day before her death when she was moved to a single cell on basic regime.

Ms B was a poly-drug user including prescribed methadone at the time of her reception. She was prescribed the standard 11-day withdrawal regime of reducing dihydrocodeine but this was stopped prematurely because of constipation and labile (unstable) mood.

On the morning of her death, Ms B had faced an adjudication (a disciplinary hearing) for using threatening, abusive or insulting words or behaviour. At the adjudication, she made an accusation of racism. The same day a nurse assessed Ms B for Styal's mental health care facility, the Reeman Unit, but did not consider it appropriate to admit her.

Ms B's partner and her mother both emphasised that she was an *"emotional person, who did not like to be on her own."* Ms B's partner noted that, as someone of mixed race, Ms B had felt herself all too visible in the predominantly white village where she grew up. In a letter to the Area

Manager for Women's Prisons, Ms B's mother called for the risk assessment of prisoners to see if they are capable of spending time alone in a single cell. She said that many mixed race prisoners, like Ms B, lacked the coping skills necessary to occupy a single cell safely. She also said she was concerned that Ms B's medication had been changed because of perceived side effects, without consulting her outside GP and detoxification programme.

Ms C

Ms C died three days short of her 19th birthday. Ms C was convicted of manslaughter, theft and other offences and sentenced to three years on 17 January 2003. She arrived late at the prison and induction was not completed. She died the next day. Ms C had spent six months on remand at Styal before being bailed in November 2002. During that period, Ms C is reported to have self-harmed on at least 28 occasions.

Ms C was discovered to be ill at 16:25 in the afternoon of Saturday 18 January, apparently by overdose of dothiepin concealed internally and brought into the prison. Ms C was in the segregation unit because she said she felt threatened by an associate. A form F2052SH was opened on reception. The file contains references to Ms C crying and asking for medication.

Ms C had a history of psychiatric illness. Medical staff requested Ms C be placed in a safer cell and/or in shared accommodation, observed regularly, medicated and referred to other professionals. She was placed in an ordinary single cell in the segregation unit. Ms C had a past history of poly-drug use but said she had been free of drugs for nine months.

Ms D

Ms D was 24. She died on Sunday 20 April 2003 by ligature made from a piece of ripped bed sheet and applied between 09:25 and 10:25 in a single cell on Waite Wing. Ms D was convicted of theft on 29 March 2003, received into Holloway that day, moved to Foston Hall on 11 April and to Styal on Monday 14 April. She had many previous convictions for drug-related crimes and theft and had spent 19 short periods in custody. This was her first time at Styal. Ms D had had many open F2052SH files during her periods in custody. There were numerous instances of her tying ligatures and she was on a 2052SH at the time of her death. She was assessed at Styal as not suitable for sharing. Her induction was apparently not completed.

Ms D was receiving medicine for psychosis and depression and she had undergone a 10-day reducing methadone detoxification at Holloway. It was not clear whether she received medication for alcohol detoxification. She would often ask for cigarettes, threatening to harm herself if she was not given any.

Ms E

Ms E was 41 years old and had three children. She died on Wednesday 4 June 2003, having used a ligature in a single cell on Waite Wing some time between 16:23 and 17:58. Ms E had been admitted to Styal the day before, remanded for sentencing having been convicted of theft. At reception, Ms E was seen by a doctor and nurse and noted to be withdrawn, depressed and anxious. A plan was made to admit her to the Reeman Unit, Styal's in-patient mental health unit. Ms E had been on a F2052SH on a previous sentence at Styal but was not on this occasion.

Ms E reported that she used heroin and crack. She was given a 'stat' dose of 10 mg diazepam. A standard dihydrocodeine detoxification regime was due to begin on 5 June.

I have spoken to Ms F, the named next of kin of Ms E. Ms F is not a blood relative but took Ms E into her home on finding her living on the streets. She said that Ms E was a clean, tidy person and that her heroin addiction was very much to the lower end of the scale. Ms E smoked but did not drink.

Ms F does not believe that Ms E killed herself. Ms E *"had a lot to live for … She was coming off the gear and wanted a better life"; "She wanted to go to prison to finish her rattle off."* Ms F said Ms E had completed two sentences successfully and that she was not a self-harmer.

The woman at the centre of my investigation

The woman at the centre of my investigation is distinguished from those of the other women in that there has been no suggestion that she and the other women who took unauthorised dothiepin intended to harm themselves. However, her circumstances, and some of the issues raised by her death, have features in common with those of the other women.

Section 2: Common issues emerging from the six deaths

An analysis has been prepared by a member of my investigation team of common issues and areas of concern emerging from the six deaths of women in custody at Styal since August 2002. I summarise below the key points and make some additional observations.

Poly-drug use and detoxification

All the women who died had a history of poly-drug use. Substance misusers are known to have a heightened risk of self-harm. The Area Detoxification Consultant to the Women's Prisons, estimates that approximately 70 per cent of all women received in the women's local prisons have severe substance misuse problems prior to their arrival and are in need of detoxification. In brief, the Area Detoxification Consultant says that the detoxification regime on offer at Styal (and many other prisons) at the time of these deaths was inadequate to treat severely dependent poly-drug users. I describe later the

steps that have since been taken to introduce a more satisfactory detoxification programme at Styal.

The women all died within a short period of admission

All the women who died did so within their first month of custody at Styal. Four died within the first week (two had been at the prison only one day); one after eight days and one after 25 days. It is an acknowledged research finding that the majority of prisoners who die in custody have been in the establishment for relatively short periods of time. According to the Prison Service's Safer Custody Group, just over half of prisoners who died in 2002 had spent less than a month in custody. That said, it is a striking feature of the Styal deaths that all occurred so soon after reception.

Concerns have been raised by the Lead Investigating Officers of at least two of the deaths that the induction process at the prison is inadequate and contributes to stress on reception into custody.

My investigation team has been told by discipline and healthcare staff of the pressure to 'process' large numbers of newly admitted prisoners often well into the evening in physical circumstances which are less than ideal. Prisoners may be kept in holding rooms for up to three hours before a member of staff is able to escort them to the wing and carry out induction. One consequence of late admissions is that prisoners may see a nurse but not a doctor.

Contact with friends and families outside may be particularly important during the first days in prison. Access to telephones was not raised in connection with any of the deaths, but I received complaints from prisoners that after their first night at Styal they could wait for 10 days or more for a PIN phone account to enable them to make telephone calls. The Governor tells me that this has recently been changed. Women now have access to the PIN phone account immediately after reception. In addition each woman is given £2 credit that does not have to be repaid. The intention is to ensure that women are not deterred from contacting families because of lack of funds.

Administration of medicines

I have considered the security of medicines on Waite Wing in the context of the woman's death in Part 1 of this report.

The investigation reports on previous deaths identify occasional instances of delay or omission in administering medication and doubt as to whether appropriate medications were prescribed.

I have recommended above that consideration should be given to providing for Waite Wing prisoners an improved environment for the administration of medicines.

Communication between medical and non-medical staff

Failures in communication have emerged as a critical theme of this inquiry.

The reception nurse who saw Ms C recommended that she be located in a 'safer' cell. Such a cell was available but discipline staff gave priority to separating Ms C from others.

The conveying of information on a prisoner's medical condition to discipline staff is raised in the investigation reports on the deaths of both Ms C and Ms B. In both cases, significant information was noted in medical records but not on the F2052SH and not conveyed to the discipline staff looking after Ms C and Ms B. The report on Ms B's death recommends that a clearer understanding should be communicated to healthcare staff about what is and is not 'medical in confidence' regarding F2052SH observations.

In the case of the woman at the centre of my investigation, it evidently did not occur to the staff who knew that a medication bottle had been found to consult nursing staff. A message calling the night nurse was left on voicemail.

Protocols for staff are of no value unless they are known to staff and translated into routine practice. I am also aware that healthcare staff have sometimes felt isolated and believe that their clinical expertise is not always valued by discipline staff and governors driven by other operational pressures.

Styal may wish to seek opportunities, perhaps through joint training as well as F2052SH case reviews, to foster collaborative working between its healthcare professionals and other prison staff. Healthcare and discipline staff alike have spoken highly of the contribution made by the recently introduced NHS Mental Health In-reach team (though I am conscious that it has recruited some experienced psychiatric nurses away from Styal's own hard-pressed healthcare team).

I am also aware that a Styal Development Council has recently been established as a forum for staff to contribute to shaping Styal's future. I hope that this may encourage cross-disciplinary understanding and co-operation.

Mental health issues

Three of the six women who died identified a history of mental health problems. Ms B identified depression on reception. This was not medically treated while she was in prison. She was assessed as not appropriate for admission to the Reeman Unit. The reason for this was not recorded. Ms C had a long history of psychiatric illness. A plan was made to admit Ms E to the Reeman Unit as she appeared anxious, depressed and withdrawn, but she died before being admitted.

Section 7 below considers mental health issues in the context of healthcare provision as a whole. I also commend the Mental Health Needs Assessment conducted at Styal in May 2002 by a Nurse Consultant. It contains valuable research, insights and recommendations.

Prisoner movements between and within establishments

Prisoners appear to be at higher risk of self-harm after re-location.

Ms A was located at Styal when Brockhill, her local prison, was full. Ms D was transferred from Holloway to Foston Hall and on to Styal. Transfer from jail to jail is a cause of anxiety for prisoners, especially when the new prison is unfamiliar and remote from the prisoner's home area. This may be compounded when, as was the case with both these women, induction is not completed.

Ms B had been recently re-located to a single cell when she died.

Section 3: Waite Wing

Five of the women who died were located on Waite Wing. Ms C was in the segregation unit at her own request, but had been held on Waite Wing previously on remand and would have been held on the wing if she had not requested segregation.

Whereas the main prison at Styal consists of houses set among avenues of trees presenting a reasonably attractive environment, Waite Wing has a forbidding and isolated appearance. The fact that the contractors' fence has remained in place separates Waite Wing from the rest of the prison site. This reinforces the sense of Waite Wing as set apart from the remainder of the establishment by virtue of its design, population and history. The Independent Monitoring Board described Styal to me as *"two prisons".* I think this is accurate.

The women on Waite Wing are likely to be more at risk than those held elsewhere in the prison. Arrangements for their care and safe detoxification are of critical importance. Yet the paucity of the regime on Waite Wing has been criticised by both HM Chief Inspector of Prisons and the Independent Monitoring Board.

The restoration of the system of administering medications at the gate (described above in relation to the events of 12 August 2003) was driven by a desire – which I commend – to reduce the time that women are locked up, and to release staff from repeated turnkey duties. A return to longer periods of inactivity and confinement to cell would fly in the face of all that the Governor and Area Manager are trying to achieve. On the other hand, I do not discount the claims of staff (and some prisoners) that extra, unstructured, association has led to greater rowdiness and intimidation. I am concerned that too little attention may have been given to bringing staff along with the new regime, to fostering the confidence they needed to carry it off, and to managing the association period. Many of Styal's staff are recently recruited to the Prison Service. The SO in charge of Waite Wing on the evening of 12 August was only recently recruited to the grade. Staff with whom my team spoke wanted to do their best for the women in their care but did not always

know how. The series of deaths has also undoubtedly affected staff morale deeply, perhaps to the extent of a fear of taking responsibility. The staff on Waite Wing need the energetic and visible support of managers, on hand to help and advise as they face new challenges.

I acknowledge that the physical environment of Waite Wing is not helpful. There is little association space off the landings. But that should not prevent structured recreations, such as games and quizzes, which I am told staff organise successfully at New Hall. (I understand that a large television screen is now on order to enable women to watch videos together.) The Governor may also wish to review whether the situation should continue whereby staff are not detailed to particular tasks during evening association.

Despite the recent extensions to the periods of association, many women spend most of their time locked in cells. I have not been able to discover how many Waite Wing women are engaged in education or employment but it seems to be few. I understand that the number of education places on the wing has recently been raised from eight per session to 24. To attend workshops, women have to be risk assessed and escorted out of Waite Wing compound. Most meals are eaten in the cell and, apart from in-cell television, there are few means of occupying time.

There are only 10 shower units on the wing, two baths and four telephones. The wing is open and has high ceilings. During periods of unlock the wing is noisy. Several people told me it was *"hectic".* It is not surprising if vulnerable women find it intimidating. Among the less timid, the opportunity to command a wide audience encourages bravado. The prisoners are vocal and demanding of attention from staff. The only recreational facilities are a bookcase and pool-table.

I am told that, during the hot weather this summer, women were on a few occasions allowed to use the compound area outside Waite Wing to take association outside. There have been suggestions that the compound could be made a more desirable facility and the Deputy Governor told us that picnic tables have been ordered.

Styal has drawn up a plan for a high intensity support day care centre for women most vulnerable to self-harm. It is hoped to secure funding for a manager and staff to run the centre all day Monday to Friday, and some staff at weekends. Two officers are already in training and it is hoped to appoint more physical training instructors. The intention is to provide activities including extra sports and games to improve the physical and mental health - and thus the morale - of the most vulnerable women. However, it is proposed to house the centre in the existing family visits area and resources are not yet available to pay for an alternative space for family visits.

I have no doubt that the new day centre will be of value and hope that it can be introduced successfully. However, experience shows that it is not always possible to predict vulnerability, and the new centre should not be allowed to distract attention from the needs of the Waite Wing population at large.

More generally, I am influenced by the encouraging findings of the Prison Service's 'Safer Locals' project which appears to have reduced levels of self-inflicted death. Safer Locals are based in part on significant improvements to the built environment. Waite Wing has now been repainted in attractive colours to soften its appearance. But Styal also urgently needs improvements to its reception area. Consideration should also be given to the design of the new wings that are to be built soon, and to splitting up the space into smaller, discrete, more homely areas. Finally, in my opinion, the fence around Waite Wing operates as a powerful – negative - symbol which may needlessly obstruct the ability of women on Waite Wing to take part in the regime of the prison. It survived by accident having been erected by contractors. I think the time may be right to remove it.

I recommend:

> **The Prison Service should review its capital spending commitments for Styal in the light of this report. The Area Manager should review the design and use of the new wings already planned for Styal. The Prison Service should consider taking down the fence that separates Waite Wing from the rest of the prison.**
>
> **The Governor should establish a review with a remit to improve time out of cell and maximise access to structured activities on Waite Wing.**

Section 4: The views of the IMB, the Inspectorate, and other interested organisations

I have reviewed the most recent report from the Styal Independent Monitoring Board and met with two members of the Board. In its Report for the period February 2002-February 2003, the Board says its main areas of concern are *"overcrowding and shortages of professional staff".* It says that detoxification facilities are *"insufficient"* and notes that there has been a big increase in the number of prisoner movements ('churn'). When I met with the IMB Chair and his colleague, they told me that Waite Wing should have its own dining area, and they criticised the lack of privacy for women in reception.

I have found HM Chief Inspector of Prisons' most recent inspection report of great value too. The Report is the result of a full announced inspection that took place in February 2002 (it was published in November 2002). The Report emphasises the absence of proper detoxification facilities, and criticises the design of the reception area and the absence of *"obviously supportive first night procedures."* The Chief Inspector writes:

> *"Styal has been described as the 'Holloway of the north' … without the resource and support needed to provide properly … particularly in relation to substance use and mental health …"*

I have also sought comments and contributions from a range of other interested bodies. I am most grateful to those who replied.

I have not reached a view on all the matters raised but I report them here both for completeness and as a guide to those charged with taking Styal forward.

The National Association for the Care and Resettlement of Offenders (NACRO) drew my attention to a variety of issues. NACRO noted that the Prison Service's approach to suicide prevention emphasises the importance of relationships in preventing suicide and self-harm and in supporting vulnerable prisoners during their sentence. Like a number of other contributors, NACRO said it was encouraging that the Ombudsman and not the Prison Service itself was investigating the occurrences at Styal.

NACRO's Housing Advice Officer at Styal told me there had recently been a new emphasis on awareness of issues to do with self-injury at the prison. She said that there had been training from the Mental Health In-Reach Team and cited some of the proposals to have emerged from this training:

The issue of proper induction and detoxification facilities. *"Some of the suggestions were to produce booklets on the induction process for the women, and to speed up the process of getting PIN numbers to make phone calls."*

Wider access to female GPs. *"Many of the women we interview have experienced physical or sexual abuse by men in the past and would not feel comfortable with a male GP."*

Greater access to counsellors to deal with emotional problems. *"The referral process to counselling services seems to be unclear, both for staff to refer prisoners and for the prisoners to refer themselves."*

Home Detention Curfew decisions *"seem to be being made at the last minute."*

The Prison Officers' Association also welcomed my investigation. In a letter dated 10 September 2003, the POA's General Secretary said the Union was currently gathering evidence on self-harm and suicides in prison. The General Secretary added:

> *"Currently, the Women's Estate is in crisis. The ability of the POA to put forward ideas, both at national and local level, is somewhat hampered by the attitude of those managers currently running the female estate. However, it should be noted that the huge increase in females entering the prison population does not help, although senior managers are given this onerous responsibility."*

The Prison Governors' Association also provided helpful views:

"We take the view that the nature of inmates held at HMP Styal is not properly reflected in the resources provided to ensure appropriate Nursing and Discipline staffing to deliver the treatment and regime required. [There is] … a huge proportion of female prisoners (almost half) who report having attempted suicide during their lives. This is considerably higher than for the general population … Histories of sexual abuse, domestic violence, drug abuse and alcoholism abound.

"HMP Styal has a turnover of about 40% of its population each month. Overcrowding further South only increases that throughput.

"Styal has a Mental Health Unit, but its ten places are woefully inadequate. PSO 3550 required Governors to provide methadone detoxification for all prisoners withdrawing from opiates, with effect from October 2001. Funding for the programme was only released in April 2003! Her Majesty's Chief Inspector of Prisons referred to the lack of detoxification in HMP Styal in February 2002.

"Even since the funding became available, the Establishment has experienced problems in recruiting appropriately qualified nurses to administer the treatment.

"Although ring-fenced funding has been provided for VDT [Voluntary Drug Testing] facilities and for drug rehabilitation, efficiency savings have still been required. These impact disproportionately upon other aspects of the regime and, by implication, upon workshop places.

"In short, we anticipate that your investigation will find a Governor and Staff endeavouring to cope with an increasingly 'damaged' population, which is 'turning over' at an even faster rate, without the resources or time to provide the sustained periods of individual attention which so many inmates at Styal desperately require."

The Prison Reform Trust (PRT) told me they were concerned by the *"high levels of mental illness, distress, chronic poor health and substance misuse (drugs and alcohol) which characterise the women's prison population."* PRT added, *"more than anything we should like to see this population reduced."*

PRT's submission to my investigation drew attention to *"much disquieting, anecdotal evidence of courts using prison as a psychiatric disposal, particularly for female offenders, either as a so-called 'place of safety' for un-sentenced women awaiting doctor's reports or as a substitute health-care facility for detox, drug treatment or medium-term psychiatric care."*

Most interestingly, PRT compared the deaths at Styal with a similar cluster that occurred at the Scottish women's prison, Cornton Vale, some years ago:

> *"The cluster of deaths at Styal is a tragedy. There are echoes of events at Cornton Vale when, following a number of suicides, staff became demoralised and felt helpless and powerless to prevent further deaths. There is much to learn from the way in which the in-coming Governor … tackled the problem on every front: enlisting HQ back-up and resources, involvement of Samaritans, intensive staff support and training … close consultation with the Chief Inspector, liaison with courts, efforts to lower the temperature in the media, more involvement of women prisoners themselves in finding solutions. All I think documented by SPS [the Scottish Prison Service] with some transferable lessons on how to try and reduce the expectation of death, after the suicide taboo has been broken, restore confidence and avoid self-fulfilling prophecy. When people say that a series of deaths in a prison does not have connecting factors, they miss the obvious connecting factor, the prison itself and the way in which the possibility of suicide has 'gone into the walls'. The point of comparison with wider society is the well documented, much increased likelihood of death by suicide where one has occurred already within the extended family."*

I recommend:

> **The Area Manager and Governor should visit Cornton Vale to learn from their experience following a series of deaths.**

The Howard League were co-signatories to a letter (signed also by the mother of Ms C and the organisation, INQUEST) asking me to suspend my investigation.

INQUEST also sent me a comprehensive submission and I have found it extremely helpful. In a covering letter, dated 8 October, the organisation said:

> *"While INQUEST welcome the investigation into [the woman at the centre of my investigation]'s death, we are extremely concerned that the Ombudsman will not be examining all the deaths at Styal. To select one death from the six that have occurred cannot capture a comprehensive overview of the systemic failings.*
>
> *"In our view what is needed is a wide-ranging independent public inquiry that examines all the recent deaths, any institutional and systemic failings and most importantly involves bereaved families and women prisoners themselves.*

We are concerned that the proposed inquiry with its limited time frame and narrow remit cannot possibly establish what is going wrong and ensure that lessons are learnt. There is a crisis in women's prisons highlighted by the increasing number of deaths and incidents of self-harm and the numbers of women prisoners with mental health and/or drug and alcohol problems. A full inquiry could examine all the deaths in this context and make a significant contribution to preventing any further loss of life."

INQUEST made a large number of points in their submission, many of which were echoed in the conversations I held with bereaved relatives. They concerned:

- The way families are notified of a death. I share INQUEST's belief that the way families are first contacted is both a critical aspect of a prison's service to the public and sets the tone for all subsequent involvement between the Prison Service and the relatives of those who have died in custody.

- Post death communication with the family, the value of having a dedicated 'family liaison officer', and the need to ensure that all information given is accurate.

- Contact with INQUEST, in particular the need to ensure that all governors are required to hand out a leaflet written by the organisation. (Amongst their evidence, INQUEST also sent me a copy of a new Information Pack for Families and Advisors they have produced. This too was a most impressive and useful resource.) I refer to both documents again later in this report.

- The need for an information pack to cover investigations. (I shall take this on board if it is decided that my office should take responsibility for investigating all deaths in prison custody.)

- The need to involve relatives in the investigative process. Irrespective of whether or not a family decides to have full participation in the process, they should still be kept informed of the progress of the investigation.

- The payment of funeral expenses. (I make a formal recommendation on this subject later in this report.)

- The need for sensitivity in the handing over of personal possessions.

- The need for independent investigators: *"There may well be a need to have prison employees involved in the investigation but the need to demonstrate independence is paramount."*

- The length and scope of investigations.

- Disclosure of information. I share INQUEST's view that, subject to the need to respect the views of the Coroner, as much information should be disclosed to the family as early as possible. In the case of the woman at the centre of my investigation, the Governor of Styal disclosed her Inmate Medical Record within a week or so of her death. (My views had been sought and I strongly supported the Governor's decision.) INQUEST told me that such early disclosure *"is a unique situation that we have never come across."* This should not be so.

I recommend:

> **New advice should be issued to Governors encouraging early disclosure of prison documents, subject to the Coroner's consent. Consideration should also be given to releasing – in whole or in part – the initial assessments (interim reports) produced by Lead Investigating Officers.**

- The wider consideration and dissemination of findings and recommendations from investigations and inquests.

- Support and counselling for staff and prisoners.

- Public funding for all families to be legally represented.

- The need to review (and, if necessary, revise) investigation reports once the inquest has been held. I agree with INQUEST that this would be good practice. Quite separately, I had already concluded that such a review would be part of my office's methodology should we be given responsibility for all death in custody investigations.

- The need for a clear line of communication between prisoners' families and the institution in which their relative is held.

Section 5: Timely investigations, sensible deadlines and the Coroner's inquest

At the time of my inquiry, the Prison Service investigation report was not complete in three out of the five deaths which occurred before the death of the woman at the centre of my investigation. I understand that delays occurred, in part, because the Area Office for Women's Prisons convened an Advisory Panel comprising among others the Lead Investigating Officers conducting the investigations, a member of my staff and the Suicide Prevention Co-ordinator for Women's Prisons.

The intention, which I commend, was to ensure the investigations were thorough and of high quality and to allow the Lead Investigating Officers to pool their observations so that lessons could be learned. Nonetheless, the value of investigations can significantly diminish as time passes, circumstances change and evidence becomes stale. If lessons can be

learned to prevent future deaths then it is axiomatic that the sooner this is done the better.

The Coroner for Cheshire expects to have the benefit of the Prison Service investigations when setting the date for an inquest. He and relatives expect disclosure of the Prison Service report to inform the inquest. Delay prolongs distress, not only for relatives but also for staff and others who may be called to give evidence. Delay undermines public confidence.

The Coroner has asked me to point out the value of timely investigations and the harm caused by delay. I am happy to do so. However, I am also conscious of a contrary problem: that of setting deadlines for investigations that are artificially short. I am not convinced that, in every case, Area Managers are setting deadlines that encourage the most detailed examination of events. They may also simply be unrealistic given that the process cannot be completed until the investigator has obtained a full post mortem report.

I recommend:

> **Safer Custody Group in Prison Service HQ should review the deadlines given to Lead Investigators, the impact on the quality of investigations, and the extent to which initial deadlines are extended.**

Section 6: Facilities for detoxification

> *"You lie there in pain mentally and you ache and you sweat. You're physically sick. You've got pains that are 25 million times worse than childbirth contractions. You got snake pains in your arms and legs. You're shitting. It's coming out both ends.*
>
> *"Lying in that cell and coming off is horrible. I was sexually abused as a child. Taking heroin may be wrong but it blocks it out. It blocks everything out. You don't phone your mum or care about your little girl or anything. Then when you're in prison and you're lying in bed it all comes back. You think where have I been for 12 months.*
>
> *"After the DFs [dihydrocodeine] you get a bad rattle from them as well."*

This prisoner was telling us about withdrawing from heroin in prison. The needs of women drug users emerge from this investigation as the most important single area of concern.

Longstanding poly-drug users have already crossed a threshold of recklessness in chemical risk-taking, but prisoners told us why in their view the woman at the centre of my investigation and others took the dothiepin.

This is what they said:

> *"I would have taken it ... Because I was not sleeping at the time ... Just to get my head down at night."*

> *"The girls that took it were midway through the so-called detox in this place and you don't get a lot of sleep, you're given nothing to help you sleep like you would be in a proper detox centre. And personally, if I was there and I was half way through a detox and I hadn't slept for nights, I'd have taken some as well. Anything to help you sleep when you're withdrawing."*

> *"I'm a drug addict and you know you come into jail. You know you don't expect wonders but you get a poxy DF twice a day. That does nothing. Honest to God, it does nothing. A lot of the girls will tell you that. It doesn't do a thing. You know it takes the edge away. It's like doing a double sentence. [The woman at the centre of my investigation] only took it because she can't sleep at night. Lights are everywhere and [she's] just tossing to sleep … I would have had some only I've got a cleaning job, two weeks now ... Thank God I'm here today."*

A nurse confirmed the view that the woman and the others wanted to sleep:

> *"Insomnia? That's the biggest problem with withdrawal … because it's at least six weeks before you get a normal sleeping pattern, but that's what they were after."*

Prisoners also commented on the 'revolving door':

> *"It's mad because there's all this getting clean in prison but nothing for when you go out. I was clean for two years in Cookham Wood but then they put me straight back on the street."*

Some had put their names down to see a CARATS (drugs) worker but said that they expected to be released before their turn came round.

A governor commented that prisons seemed to have adopted a strange attitude to drugs. They knew people were drug addicts but were surprised when they continued to take drugs in prison. The remand wing was a microcosm of the outside world. Women came straight off the streets. The prison needed to accept their immediate situation, identify the drugs they were taking, and let them down gently with medication appropriate for each patient and short programmes to support them. Nothing was gained by taking a punitive attitude.

There was unanimous agreement among the prison managers, the healthcare staff, and the consultants we spoke to, that a detoxification regime of standard

doses of dihydrocodeine (DF118) was inadequate. (The Area Detoxification Consultant for Women's Prisons explained that Styal's regime at the time of the series of deaths was no better or worse than that on offer in many other prisons.)

A new approach has been introduced with the introduction of PSO 3550 on Clinical Services for Substance Misusers. But funding is still very limited and, even where funding is available, there are problems of recruitment and retention especially of nursing staff (as at Styal).

The Governor of Styal led a bid some two years ago to secure NHS funding for a dedicated detoxification unit. Great hopes were invested in that initiative but funding was not granted.

Limited Prison Service funding was made available in the last quarter of 2002/2003 but it was not recurrent funding. Nonetheless, some progress was made in preparing to introduce new detoxification facilities in a specific area of Waite Wing. Unfortunately, it has been impeded by the long-term sickness of the appointed manager and difficulty in recruiting and retaining nurses. The Head of Healthcare has launched a number of enterprising recruitment initiatives but so far with limited results. The shortage of full-time nurses places great strain on the existing staff who sometimes feel they have to 'baby-sit' agency nurses, inexperienced in the prison environment, but whose terms and conditions are more attractive than their own. The Head of Healthcare, who is a highly qualified and experienced nurse manager seconded from a Primary Care Trust, often has to step in to provide front line nursing.

After the death of the woman at the centre of my investigation, it was decided to delay no longer in introducing a methadone detoxification programme. This began during our investigation and, properly resourced, it should offer a far more appropriate treatment regime. However, my consultants expressed concerns about the environment in which detoxification was being delivered and the adequacy of the resources to sustain it.

I recommend:

> **The Governor and Area Manager should review arrangements for methadone detoxification in the light of my consultants' concerns.**

Nursing staff also expressed concerns that the methadone programme depleted still further the nursing cover for the remainder of the prison. The Head of Healthcare was repeatedly called out to act as the second nurse when methadone needed to be administered during the night shift when only one nurse was on duty. There was concern that the physical facilities were not yet in place to allow safe and secure methods of working, for example for the disposal of urine samples in reception.

On the other hand, both nursing and other staff commented on the benefits already evident of being able to provide a detoxification regime which manifestly alleviated women's distress to a much greater extent than formerly. Wing staff told my healthcare consultants that it was good no longer seeing women shake and twitch while waiting for medications.

Section 7: Healthcare

A number of people told me that healthcare should be at the heart of the regime for the vulnerable population of the Wing. A way needed to be found of integrating healthcare, for both acute needs and longer-term health promotion, with the routine of the prison so that they were not pulling against each other. Some said that meeting healthcare needs equals constructive activity; they should *"design the regime around healthcare".* One very senior figure told me that *"sensible, confidential healthcare"* should in essence constitute the regime on Waite Wing. I share that sentiment, as I have indicated earlier.

I have also referred elsewhere to the pressure under which healthcare staff are working at Styal. There is a chronic shortage of nurses; existing staff, including managers, work under unreasonable stress; some nurses feel undervalued and poorly rewarded; some told us that they are being required to work in ways which put their registration at risk.

The Head of Healthcare told us that shortage of nursing staff meant that all but the most acute services had to be sacrificed:

> *"For example, we're not meeting healthcare standard audit requirements at the moment in our chronic disease management and our promotional activities. So we're not pro-actively managing our women with asthma or chronic heart disease. We don't have a fully established well women's screening clinic. Our sexual health services are currently compromised as a result of staffing and the nursing staff on duty end up doing the core activities which in itself can be very demoralising and demotivating. They feel like all they're ever doing, is escorting for GP surgeries and administering medications, vital and essential though those activities are ... We have recently established smoking cessation services, hepatitis B immunisation, there are lots more things we should be doing to meet healthcare standard audit requirements and it's difficult to do that without the staff in post to do it. So they either don't happen, or they happen in a limited way."*

In her management report for July 2003, the Head of Healthcare recorded:

> *"Acute staffing problems due to staff moves to Mental Health In-Reach posts, sickness and recruitment. Reeman Unit using night staff [ie prison officers] due to nurse shortages.*

Plans to use officers for day care also. In my opinion the pressures are so acute as to justify 'Red' status."

Governing and nursing staff at Styal take pride in the Reeman Unit, the prison's in-patient mental health facility. It provides a refuge for the most seriously mentally ill women who can be treated in a healthcare setting. Psychiatric nurses are able to apply their clinical skills in a therapeutic environment. Consultant psychiatrists visit the Reeman Unit patients regularly and this may mean that they are more readily available to see other Styal prisoners than would otherwise be the case.

I do not underestimate the value of these factors. However, the existence of the Unit has given rise to some concerns.

In her inspection report, HM Chief Inspector of Prisons comments that of the seven current in-patients in the Reeman Unit, five needed care in the NHS. Because of the failure of the NHS nationally to provide an adequate number of secure psychiatric beds, patients waited for months in the Reeman Unit. Moreover:

"This unhappy situation was worsened by the fact that some of the most disturbed, mentally disordered women could not be managed in the Reeman Unit and were being held in segregation. At the time of our visit, two patients were being held in segregation awaiting NHS care. Despite the efforts of staff in the Reeman Unit, the care there is not equivalent to that in the NHS. Healthcare in the Segregation Unit was, by its nature, minimal ...The Prison Service should press the Department of Health to provide sufficient secure mental health beds to ensure an adequate service for prisoners.

"Although we understood the value of the Reeman Unit in allowing very sick women to get a level of treatment not available in most women's prisons, we had great concerns about the wider impact it was having. Unfortunately, it was coming to be seen by some courts as a specialist unit for seriously mentally ill women where NHS equivalent care was available. Consequently, courts were sending women to prison rather than arranging a more suitable disposal to the NHS. The [Prison Health] Policy Unit and the Task Force should consider how the Prison Service could ensure that, while providing high quality care, it does not disadvantage mentally ill prisoners by delaying their admission to the NHS."

We were also told of anecdotal evidence that other women's prisons had a mistaken view of the Reeman Unit as a national resource. There were cases of highly disturbed women being sent to Styal from other areas and, on arrival, one woman said she had been told she was going to Styal to hospital.

Nurses told my investigators of concerns that decisions on admission to the Reeman Unit were not always made on clinical grounds. They said that, especially at weekends, they were sometimes instructed by governors to admit a woman, and discharge another, against their clinical judgement. One nurse said that two patients in the Reeman Unit at the time of the investigation were there not because they were mentally unwell but because they were at risk of suicide. Equally, a woman who had been in the Reeman Unit had been transferred to the segregation unit for a few days because she was keeping everyone in the Reeman Unit awake.

Staffing of the Unit is under intense pressure. A nurse said that the Reeman Unit should have 13 full-time members of staff but at the time of the investigation had only six. That meant operating sometimes with numbers she considered unsafe and with inexperienced agency nurses. Officers also worked in the Unit because of the shortage of nursing staff and some nurses felt it helpful to work alongside prison officer colleagues. The Unit no longer had a nurse overnight as it used to do. There was only one nurse overnight for the whole prison. When the Unit Manager went on long-term sick leave, there was no acting manager for some time because no one wanted to volunteer.

I recommend:

> **The Area Manager, Governor, Head of Healthcare and NHS partners should review the role and staffing of the Reeman Unit in the light of the present pressures on healthcare staff at Styal, the detoxification programme and the healthcare needs of the vulnerable population of the prison as a whole.**

PART 3: THE EXPERIENCE OF BEREAVED FAMILIES

The submission from INQUEST contained many recommendations regarding the needs of bereaved relatives. Here I report on my own contact with the families of those who have died. In particular, I set out the treatment they describe themselves as having received from Styal and from the subsequent Prison Service investigation into their relative's death.

The woman at the centre of my investigation

The family of the woman decided not to meet with me personally but asked that I forward a series of questions via their lawyer. In the immediate aftermath of the woman's death, and with concerns for her two children, I entirely understand that decision.

In reply to my letter, the woman's sister told me that she had received a telephone call at around 12:20am on 13 August from the Governor. The sister said she offered to go straight to the prison but was told that there was very little she could do as they were waiting for the police. The Governor told her that she thought the woman had taken drugs, but the sister said she could not understand how that could happen when her sister had had no visits.

Her next connection with the prison was at 09:15 the following morning. The sister told me she was hysterical, given she had the woman's two children in her care. The Governor told her that the woman had been taken to Macclesfield Hospital and gave her the phone number. That afternoon, she received a telephone call from the Coroner's Officer who said she had been present for the post mortem and asked if the sister had a solicitor.

The sister said that on the Saturday following the woman's death (16 August), she travelled to Styal with her brother and sister. She continued:

> *"It takes about an hour to travel to the prison. I called to the main gate and was asked if they could help me. I told them that I was [the woman's] next of kin and I had come up to collect her belongings. I was told to wait and someone would be over to see me. I thought that I may have been taken into a little room to make things more discreet but this wasn't done. I was left approximately 20 minutes. I was taken into the locker area and asked to sign for [the woman's] belongings. I was given her possessions. I wasn't even offered a cup of tea and nor were my brother or sister. I was actually physically ill at the gate. I then travelled back to Liverpool.*
>
> *"[The Governor] contacted me on the morning of Monday 18 August. She told me that she had some money to pay to me and asked if I would like to come up and collect it. I told her I had no intention of coming back up, particularly in light of the*

way I had been treated when I went up there. The following day I received flowers by way of an apology for the way I had been treated at the prison on Saturday 16 August."

The sister said that the Governor had come to her home on 21 August. Her solicitor was also present. She said she received a cheque for approximately £6 and was handed a letter that her sister had written prior to her death. She added:

"I was also told that the prison were holding a memorial service which was actually taking place as [the Governor] was with me. I do not recall anyone telling me about this prior to her calling to see me. I do not think I would have gone anyway given the way I was treated when I went to pick up the belongings.

"I recall getting flowers on the day of the funeral from [my sister's] friends at the prison. I do not recall getting a wreath or any contact from the prison on the date of the funeral. No one from the Prison Service attended the funeral. I have not heard from the funeral directors that the balance of any costs incurred has as yet been met. I understand that the Prison Service were to assist with any additional costs. I do believe that someone from the Prison Service hierarchy could have called to my home sooner to explain what had happened. I should not have been left in a position of having to tell [the woman's] children what had happened to their mother without some support or an explanation. Her children are 13 and 14 years of age and are old enough to understand. I was left to tell them personally."

The Governor had told me that, regrettably, the woman's sister and her brother and sister were treated in the discourteous way described above when they came to collect the woman's belongings. The flowers from the woman's 'friends at Styal' were in fact from the prison. I understand that the Governor made arrangements with the Funeral Director to pay the bill on the day she received it but she may wish to confirm to the woman's sister that the bill has been settled.

Ms E

I met Ms E's named next of kin at a neutral venue in her home town in North Wales. She was accompanied by Ms E's eldest child, a son now aged 19.

Ms E's son has had two contacts from Styal - one a few days after Ms E's death and one a day or two before her funeral. The prison offered to attend the funeral but Ms E's brother and sisters said no. Ms E's son himself would like to visit the cell where his mother died.

I recommend:

Ms E's son should be offered the opportunity of visiting the cell where his mother died.

Ms E's next of kin raised concerns over the limited amount of Ms E's property returned to her. She had been invited to visit the prison but had not been invited to a service of remembrance. Institutions have their own grieving process and services in memory of someone who has died play an important part - as Prison Service Order 2710 recognises.

I recommend:

Prisons should ensure that prisoners, staff and relatives all have an opportunity to attend memorial services.

I have spoken with the Prison Service investigator in the case of Ms E and suggested that he might wish to re-approach Ms E family and next of kin.

Ms B

I received a detailed letter from Ms B's mother. She had also spoken at length by telephone with a member of my investigating team.

In her letter, Ms B's mother began by referring to the pain she felt on learning of another tragic death at HMP Styal. It is a feature of all bereavements that subsequent deaths re-awaken the sense of loss. She said her grief at losing her daughter remained very strong.

Ms B's mother said she had continuing grave concerns regarding the *"care policies for inmates at Styal."* She had written to the Area Manager and the Senior Investigating Officer (SIO) investigating her daughter's death in April 2003, but neither letter had been acknowledged. She also said that the SIO had promised that she would see his report *"within approximately three weeks,"* but it had never arrived.

I have not attempted to investigate these claims. I am conscious that my own involvement with the families of those who have died may not have satisfied everyone. As one of the SIOs involved in the Styal tragedies said to me, *"There is no 'right way' of involving families."* Few things could be more offensive than badgering bereaved relatives. On the other hand, Ms B's mother's testimony draws attention to the importance of simple courtesies like acknowledging letters and of not making commitments that cannot be met.

I recommend:

The Area Manager and SIO should review the correspondence they have had with Ms B's mother.

I also met with Ms B's partner. He learned of Ms B's death while he was on remand at HMP Altcourse. He had been called out of an I.T. lesson by the

chaplain at 1.15 pm (within 75 minutes of Ms B's death). The chaplain had told him the news, although she had not known the cause of death. He was seen by the wing governor and offered bereavement counselling which he attended once then declined. He was offered a private meeting with his father (although not with Ms B's mother) and a private phone call. Ms B's partner *"has no criticism of Altcourse."*

He is, however, much more critical of what he was allegedly told by Styal. In particular, he says that, despite a commitment to the contrary, details of Ms B's death were passed to the press before his children had been told. He also alleges that the initial details of Ms B's death that Styal supplied to him failed to mention that she had previously been in a shared cell and that she had been adjudicated upon. He says he learned this in letters from other prisoners at Styal (the details he gave are correct).

Mr B's partner attended Ms B's funeral but, because he was double-handcuffed and on a chain, he asked his parents not to attend. He has had returned to him his letters to Ms B, but no other property. Ms B's partner had been invited to contribute to the Prison Service investigation but declined. He told me this was partly because of his then emotional state, and partly because he did not think he could talk freely to an internal Prison Service investigator. There has subsequently been protracted but unsatisfactory correspondence involving himself and his lawyer regarding access to the internal report.

I understand the Prison Service's concern to be seen to be open and I know that news of a death in prison may reach the media through unofficial sources. Nonetheless, it must be acutely hurtful for a family member to learn of a death from the press.

Ms A

I met with the parents of Ms A at their home in the Midlands. Ms A's brother was also at home. Ms A also had three older sisters, all living close by.

Ms A's parents said they had found the newspaper reporting upsetting. Coverage of their daughter's death had started even before they had formally identified her body.

Like Ms E's next of kin, Ms A's parents were concerned that some items appeared to be missing when property was returned. Some aspects of their involvement with the prison had been sensitively handled. In particular, they had welcomed the visit they had received from two members of Styal's staff (I also saw a kind and caring letter from the Governor), and the fact that one had attended their daughter's funeral. The prison had part-paid for the funeral expenses, the Department for Work and Pensions meeting the rest. However, they said they had received no invitation to a memorial service or to see their daughter's cell.

Ms A's parents had received one letter and one phone call from the Prison Service investigator charged with investigating Ms A's death. They had not been invited to meet him personally. I note that in a letter dated 21 August 2002, the Prison Service investigator said:

> *"My investigation report when complete will be sent to the coroner in the expectation that he will authorise its disclosure to you. I would then write to you to offer to meet with you to go through the report, or to post it if you would prefer."*

The investigating report and its various enclosures was on Ms A's parent's sideboard when I met them. Although I am sure it was intended well, nothing further had been heard of the offer to go through the report with them. The moral is self-evident: when people are at their most vulnerable through bereavement, great care should be taken before offering contact that will not actually be delivered.

I recommend:

> **The Governor of Styal should consider if further contact should be made with Ms A's parents in the light of their concerns outlined above.**

Ms D

I have made various attempts to contact the father of Ms D. Unfortunately, these have proved unsuccessful to date. Although I have now submitted my report, I shall of course make myself available to Ms D's father if he requests a meeting.

Ms C

I met Ms C's mother at the offices of her solicitor. She had also requested the attendance of representatives of INQUEST and the Howard League. Ms C's mother left me in no doubt as to her anger at what she sees as the failures of the criminal justice system in its care of her daughter. She said HMP Styal should be *"closed down."*

Ms C's mother told me she had four other principal objectives:

- That legal aid should be extended to the families of the deceased at inquests.
- That she should not be limited in the amount of bereavement counselling offered by the NHS.
- That the use of imprisonment for women should be reduced.
- That she and other bereaved relatives should automatically be offered help with funeral expenses.

Ms C's mother criticised Prison Service internal investigations of deaths in custody: she had refused to meet with the Prison Service investigator as she felt it would be *"a waste of time."* She also made detailed criticisms of the way she was informed of her daughter's death and alleged there was an opportunity missed when her daughter was still alive and when she could have been contacted.

I note Ms C's mother's complaint that she was not told when her daughter's post mortem would take place. Although this is not directly the responsibility of the Prison Service, bereaved relatives are provided with no standard information following a death in prison. INQUEST have argued that it should be mandatory on Governors to give out their own leaflet 'What to do when someone you know dies in prison'. Alternatively, a Prison Service-wide leaflet for families might be produced. Although the inclusion of a leaflet either with or shortly after a letter of condolence might appear a rather heartless and bureaucratic approach, on balance I think the advantages outweigh the disadvantages.

I recommend:

> **The Prison Service should develop an information leaflet along the lines suggested, or require Governors to distribute the leaflet and Information Pack produced by INQUEST.**

Ms C's mother received no offer of help with funeral expenses. In part, this may have been an unintended consequence of her own decision to reject any direct contact with the prison (likewise, she received no invitation to attend a service). Be that as it may, I think the Prison Service should clarify that it will always offer help with funeral expenses unless the bereaved family specifically ask that this does not happen.

I asked Ms C's mother if she would now accept an offer to meet funeral expenses. She told me she would only accept such expenses if the Prison Service ensured that, from now on, all relatives in her position received a like offer.

I recommend:

> **The Prison Service should always offer to meet the reasonable costs of funerals.**

PART FOUR: CONCLUSION

Subject to the findings of the inquests, it appears that in each of the deaths reviewed in this report the victim's own actions were the primary cause. The case of the woman at the centre of my investigation is different from the others insofar as I have uncovered no evidence to suggest that her death was intended. The intentions of the other women who have died can only be guessed at.

The six women are, however, united by many aspects of their circumstances. The single most important factor is a history of drug abuse. Other factors affecting some or all of the women were mental health problems, fractured relationships and unstable living arrangements. Whatever the offences that brought them to Styal, all the women who died were women at risk.

So are many of their fellow-prisoners. The population of prisoners at Styal, especially on Waite Wing, is an intensely vulnerable one. Most of the women on Waite Wing are affected by poly-drug dependence and mental health issues, often in combination.

Of course, even the most damaged and vulnerable prisoner in Styal is, to some degree, the author of her own misfortunes. And it is not hard to understand the frustration of magistrates and Judges when faced with offenders like the woman at the centre of my investigation, whose record dated back two decades, who offended while on bail, and who appeared unable or unwilling to keep appointments. That said, I share the view of virtually everyone I have spoken to during this investigation – staff, prisoners, relatives, outside interests – that the current use of imprisonment as reflected in Styal, Holloway and the other women's prisons, is disproportionate, ineffective and unkind. I am particularly struck by the fact that, but for the writing of court reports, the woman had no involvement with the Probation Service after 1995.

What also united the women is their experience of Styal Prison, or rather Waite Wing itself. Although the comparison is not perfect, I am aware of the discrepancy in resources allocated to Holloway compared to Styal. In the course of this report, I have indicated some of Styal's needs both in terms of capital spending and staffing.

In reviewing the circumstances leading to the death of the woman, I have criticised decisions made by some staff. However, I am equally conscious that staff in Styal and other prisons frequently save life through prompt and dedicated care. Those actions are rarely the cause of detailed investigation reports like this one, and are rarely brought to the attention of the public. Likewise, I think there is insufficient public awareness of the pressures placed on prison staff. In most occupations, a moment's inattention, an error of judgement, or an off-day, do not risk fatal consequences. But appreciation of these truths does not detract from the fact that in law, as well as in humanity, prison staff and the Prison Service, acting on behalf of the state, have a duty to protect life and to apply lessons from adverse incidents.

This report has revealed the inadequacy of the regime and procedures in place at HMP Styal during the period covered by these six tragic deaths. My hope is that its publication and dissemination may help contribute to reducing the chances of further deaths in the future.

LIST OF RECOMMENDATIONS

THE CIRCUMSTANCES AND EVENTS SURROUNDING THE WOMAN'S DEATH

1. The safe, secure and appropriate administration of medications

1.1 The Governor and Head of Healthcare in conjunction with senior representatives of the North West Prison Health Development Team and Prison Health should consider this report, including the advice from my consultants, and review whether there are other practical measures that should be added to the action plan (page 26).

1.2 The Governor and Area Manager should consider whether changes can be made to Waite Wing to provide an environment for the administration of medication that:

- permits effective communication between nurse and patient that is out of the hearing, and preferably out of the sight, of other prisoners;
- facilitates communication and co-operation between nurses and officers;
- allows nurses to observe the ingestion of medication; and
- ensures that medicine supplies are out of reach of patients (page 26).

1.3 Whilst taking note of the consultants' observations about the unsatisfactory environment in which the nurse who administered medicines on Y side was working, the Prison Service should take advice from the Nursing and Midwifery Council about the loss of the bottle of dothiepin from a nurse's trolley and consider whether any other action is necessary (page 26).

2. Closed circuit television system

2.1 The Governor of Styal should review the use of the electronic monitoring equipment installed throughout the establishment to ensure that responsible staff understand the system and are able to use it efficiently for its intended purpose (page 28).

3. The failure to report the finding of the dothiepin bottle

3.1 The Governor of Styal should examine whether the failure by two members of staff to report the finding of the bottle indicates shortcomings in induction, refresher and security training and in management (page 28).

3.2 The Prison Service will also wish to consider whether the incident should be the subject of a disciplinary enquiry (page 28).

4. Nursing care provided at 20:20 hours on 12 August 2003

4.1 The Governor, Head of Healthcare, the Healthcare Adviser for Women's Prisons and Prison Health should take note of my consultants' observations and consider what measures need to be taken to inform and support nursing staff in the care of patients during detoxification (page 29).

4.2 In conjunction with Prison Health, the Prison Service should consider the extent to which a prison can meet its duty of care by relying on a cellmate to raise the alarm (page 29).

4.3 Again whilst taking note of the consultants' observations, the Prison Service should take advice from the Nursing and Midwifery Council on the nursing care provided to the woman at 20:20 hours on 12 August and consider whether any other action is necessary (page 30).

5. Delay in bringing a nurse

5.1 The Governor of Styal should examine whether the failure to ensure that a nurse was called promptly indicates shortcomings in training, management and guidance to prison staff on the action to be taken by prison staff when women are ill (page 30).

5.2 The Prison Service will also wish to consider whether the failure to ensure the timely attendance of a nurse should be the subject of a disciplinary enquiry (page 31).

6. Handover at change of shift

6.1 The Governor of Styal should review handover arrangements at change of shift with special attention for the need for discipline staff to be aware of any health concerns (page 31).

6.2 The Governor of Styal should review incident reporting procedures in the prison (page 32).

7. The care given to the woman and others from 21:15

7.1 The Governor of Styal should write to the nurse who called for help for the woman to tell her of the consultants' warm remarks about her conduct on the night of 12 August (page 32).

7.2 At the next convenient opportunity, the Governor of Styal should draw the attention of all staff to my commendation of those on duty on the night of 12 August. I hope she will also consider if individual staff

should be acknowledged through the Prison Service's Performance Recognition Scheme (page 33).

WHAT CAN BE LEARNED FROM THE DEATHS OF WOMEN AT STYAL TO PREVENT A RECURRENCE?

8. The Wing

8.1 The Prison Service should review its capital spending commitments for Styal in the light of this report. The Area Manager should review the design and use of the new wings already planned for Styal. The Prison Service should consider taking down the fence that separates Waite Wing from the rest of the prison (page 42).

8.2 The Governor should establish a review with a remit to improve time out of cell and maximise access to structured activities on the Wing (page 42).

9. Sharing experience

9.1 The Area Manager and Governor should visit Cornton Vale to learn from their experience following a series of deaths (page 45).

10. Early disclosure

10.1 New advice should be issued to Governors encouraging early disclosure of prison documents, subject to the Coroner's consent. Consideration should also be given to releasing – in whole or in part – the initial assessments (interim reports) produced by Lead Investigating Officers (page 47).

11. Timely investigation

11.1 Safer Custody Group in Prison Service HQ should review the deadlines given to Lead Investigators, the impact on the quality of investigations, and the extent to which initial deadlines are extended (page 48).

12. Detoxification

12.1 The Governor and Area Manager should review arrangements for methadone detoxification in the light of my consultants' concerns (page 50).

13. Healthcare

13.1 The Area Manager, Governor, Head of Healthcare and NHS partners should review the role and staffing of the Reeman Unit in the light of the present pressures on healthcare staff at Styal, the detoxification programme and the healthcare needs of the vulnerable population of the prison as a whole (page 53).

14 The experience of bereaved families

14.1 Ms E' s son should be offered the opportunity of visiting the cell where his mother died (page 56).

14.2 Prisons should ensure that prisoners, staff and relatives all have an opportunity to attend memorial services (page 56).

14.3 The Area Manager and SIO should review the correspondence they have had with Ms B's mother (page 56).

14.4 The Governor of Styal should consider if further contact should be made with Ms A's parents in the light of their concerns outlined in the report (page 58).

14.5 The Prison Service should develop an information leaflet along the lines suggested, or require Governors to distribute the leaflet and Information Pack produced by INQUEST (page 59).

14.6 The Prison Service should always offer to meet the reasonable costs of funerals (page 59).