

**Investigation into the circumstances surrounding the
death of a woman, a prisoner at HMP & YOI Styal, in
May 2008**

**Report by the Prisons and Probation Ombudsman
for England and Wales**

June 2009

This is the report of an investigation into the death of a woman, a prisoner at HMP & YOI Styal. The woman was taken ill in her room during May 2008 and died shortly afterwards in hospital. I offer my sincere sympathy and condolences to all of the woman's family and friends for their loss.

I must apologise to the woman's family for the delay in issuing my report. My investigation was suspended for several months whilst I awaited the outcome of the toxicology report. Following completion of the post mortem and toxicology reports, the woman's death was determined to have been caused by acute asthma.

The investigation was carried out on my behalf by a colleague. An independent review of the woman's medical care in prison was carried out by a clinical reviewer on behalf of the local Primary Care Trust. I am most grateful to the clinical reviewer for the time that he has put into this investigation.

I would also like to thank the Governor and staff of Styal for their full and ready co-operation.

It is clear that the woman had much on her mind during her nine weeks at Styal. She received a lot of contact and support from staff, particularly during her first weeks in prison, and from her room-mate on Barker House. Nevertheless, my report highlights several areas in which more could have been done more for the woman. I am particularly saddened that the woman was eligible for release on home detention curfew four days before her death, but no decision was made about her suitability as the relevant forms had not been completed on time. I make eight recommendations.

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

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Prisons and Probation Ombudsman

June 2009

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SUMMARY

The woman began a term of 33 weeks imprisonment at HMP Styal on 6 March 2008. The woman saw a nurse at reception and said that she had used drugs for a number of years. She began a substance misuse programme on the same day that continued throughout her time at Styal. The woman also told the reception nurse that she was around eight weeks pregnant, but did not want to have the baby. After discussing this further with a prison doctor, the woman was referred to a local clinic and had a termination around five weeks later.

In addition, the woman had a history of poorly controlled asthma. She did not mention that the condition was serious and her community doctor's surgery was not asked for her records. Throughout her time at Styal, her substance misuse, termination of her pregnancy and, later, her depression, were seen as the priority. Although she apparently began to have difficulty breathing during the last week or so of her life, the woman did not discuss this with staff at the prison. I recommend that healthcare staff ensure that the patient's community medical records are requested for all new receptions who report a chronic disease in their medical history. I endorse a recommendation made by HM Chief Inspector of Prisons regarding chronic disease management at Styal.

On 5 May, the woman was seen by a nurse in a substance misuse clinic. She was emotional and tearful following her recent termination. The nurse therefore opened an ACCT form (the document used by the Prison Service to monitor and support prisoners deemed to be at risk of suicide or self-harm). The nurse later recalled that the woman showed no sign of having any difficulty breathing during this assessment. A prison officer who undertook an ACCT assessment interview with the woman later that day, agreed that she neither showed nor spoke of any physical symptoms.

The following afternoon, the woman was apparently "breathing heavily" in the kitchen, where she worked. A staff member in the kitchen took her to a nearby house to borrow an inhaler, after which the woman said she was "alright". There is speculation that the woman did not have an inhaler at the time and may have gone for some days without one. It is not clear whether there is any truth in this.

At around 3.30am one morning in May, the woman woke her room-mate and said that she was struggling to breathe. A nurse was called to the room but, shortly afterwards, the woman went into cardiac arrest. The woman was taken to a local hospital where she was pronounced dead at 4.58am. The cause of death was acute asthma. Although it would have made no difference to the final outcome, my report highlights several areas in the response to the woman's collapse that could be improved in future.

The woman's eligibility date for release on home detention curfew was 3 May 2008. However, the necessary assessments were not completed and no decision was made. Amongst my eight recommendations, I advise that the Governor ensure that such assessments are completed in line with the relevant national instructions.

THE INVESTIGATION PROCESS

1. The investigation was opened on 8 May 2008 when my investigator issued notices announcing it to staff and prisoners. The notices included an invitation to those who wished to submit information relating to the woman's death to make themselves known to my investigator. No prisoners came forward as a result.
2. My investigator first visited Styal on 13 May. He toured the prison, including visiting the room on Barker House where the woman lived, and was given copies of the woman's prison files. On 10-11 June, my investigator visited Styal for a second time and interviewed the woman's room-mate and four members of staff. Another member of staff was interviewed at my office in London on 24 June. My investigator returned to Styal on 9-10 July to interview a further five members of staff and again on 13 August when one additional member of staff was interviewed.
3. The investigation was then suspended for around three months whilst the outcome of the toxicology report was awaited. A post mortem report had shown that the woman had died of a massive asthma attack. However, the results of the toxicology report indicated that the woman had taken a potentially fatal quantity of methadone (medication used to treat the withdrawal symptoms experienced when a patient stops using heroin). The toxicologist commented that:

"It is possible that this concentration of methadone could prove fatal, however this will depend on the degree of tolerance that the user has acquired to the effects of the drug."

4. A clinical review, examining the medical care that the woman received at Styal, was carried out by a clinical reviewer, the Associate Director of Clinical Effectiveness at the local Primary Care Trust. The clinical reviewer discussed the cause of death with the toxicologist, and explained the woman's history and the level of methadone maintenance dosage she was receiving at the time. The toxicologist considered that the level of methadone in the woman's blood was consistent with the 30mg dose she was receiving. The clinical reviewer discussed these results further with the pathologist who completed the post mortem report. Both the pathologist and toxicologist agreed that the cause of death was attributable to a very severe asthma attack. The clinical reviewer makes the following comment in his clinical review:

"As far as can reasonably be determined, the woman died from a very severe asthma attack; her then current levels of methadone and diazepam were not contributory factors."

5. Once the cause of death was clarified, my investigation was reopened on 12 January 2009. My investigator then interviewed a further five members of staff in February and March. A total of 16 staff and one prisoner were interviewed during the course of my investigation.

6. My former senior family liaison officer telephoned the woman's mother on 22 May, to inform her of the investigation. The woman's mother said that any questions she wanted to raise had already been answered by the prison. She went on to say that she had been treated really well since the woman's death and that the prison's family liaison officer, had been "fantastic".
7. My report was sent in draft to the woman's parents, the Prison Service and the Lancashire Probation Area. The Prison Service's response to my recommendations is included in the 'Recommendations' section on page 26 of this report. The Lancashire Probation Area's response is included in paragraph 90. The woman's mother gave the following comment to my senior family liaison officer, in response to my draft report:

"We feel that our daughter was failed by the justice system. She should have been at home on 3 May and maybe there would have been a different outcome. Also the way we were told about her death was very distressing. Nobody should have to hear over the phone of their child's death and this is something me and my husband will never get over."

HMP & YOI STYAL

8. HMP Styal opened as a women's prison in 1962. In April 1999, the population increased by 60 per cent following the opening of a new wing. Styal is the only local prison for women prisoners serving the North West and North Wales. It mainly holds women serving short sentences or those on remand. The prison has an operational capacity of 460 women.
9. Styal is made up of two types of accommodation. There is a conventional wing, Waite wing, holding around 135 women in cellular accommodation. There are also 16 Victorian villas, including Barker House where the woman lived. Each of the villas accommodates up to 28 women in shared rooms of two to six people. Each villa also has a common room with televisions, stereos, DVD players, and a variety of board games. These houses have lower levels of staffing, with no staff on duty during the night. Location on Waite wing or the houses is determined by the level of risk that a woman presents.
10. Healthcare services at Styal are commissioned by the local Primary Care Trust. A doctor is based in healthcare during the daytime and evenings on weekdays. An on call service is available overnight and at weekends. There are nurses on site 24 hours a day. During the night nursing staff are based in the first night centre, as there are no inpatient facilities at the prison.
11. HM Chief Inspector of Prisons conducted a full announced inspection of Styal in September 2008. HM Chief Inspector reported that:

“Women had reasonable access to most health services, but there was significant pressure on services and staff struggled to meet women's considerable mental and physical health needs.”
12. HM Chief Inspector went on to say that some clinical services were “underdeveloped” and that “access to some health services was not as good as in the community”. She noted that there were no chronic disease (a disease that is long lasting or recurrent, including asthma) clinics and her recommendations to the Prison Service included the following:

“Chronic disease management should be improved and women should be seen regularly with support from community nurse specialists.”
13. In their annual report for 2007/2008, the prison's Independent Monitoring Board (IMB) noted difficulties in recruiting and retaining nursing staff. They related this high turnover in staff to the challenges entailed in dealing with a demanding population. The IMB also noted that the healthcare budget was significantly under-spent during the year 2007/2008, as it had been the previous year too. They made the following comment:

“Bearing in mind the nature of the Styal prisoner population and their unique and varied health issues, it is unacceptable that the budget is

not managed in such a way to ensure all the resources needed by the prison are acquired.”

14. The woman’s death was the sixth to have occurred at Styal since April 2004, when I began investigating all deaths in prison custody in England and Wales. There has subsequently been one further death. The woman’s was the second death due to natural causes. The earlier natural cause death occurred just over a week before the woman died. It also involved a woman who had arrived at the prison within a period of weeks before she died and who was being treated for substance misuse. Other than this, there were few similarities between the issues I have addressed in the two investigations.

KEY FINDINGS

15. The woman had a long history of poorly controlled asthma. She had attended Accident and Emergency in 2006 following a severe asthma attack and she regularly saw her doctor in the community for treatment. The clinical reviewer notes that, even when well, the woman had a peak flow (a measurement of how well the lungs are working) of about half that expected for a person of her age.
16. Shortly after her arrival at Styal, the woman was assessed by a prison nurse for a first reception health screen (a routine health screen for all new arrivals into prison). The woman told the nurse that she was around eight weeks pregnant but did not want to have the baby. She also said that she was using heroin, cocaine and benzodiazepines (sedative medication to treat conditions such as anxiety or insomnia that is also used recreationally and is addictive if taken regularly). The woman went on to say that she was taking a maintenance dose of methadone in the community and took fluoxetine (commonly known as Prozac) for depression. She also said that she was asthmatic. The prison nurse referred the woman to the prison doctors regarding her substance use and her physical health.
17. Later that day the woman was seen by a prison doctor. The woman elaborated on the information she had given the nurse earlier. She said that she had taken two bags of heroin daily for 15 years and had smoked crack cocaine daily for five years. The woman also said that she took salbutamol (medication used to open up the airways in the lungs) for her asthma. The prison doctor prescribed a course of diazepam (commonly known as Valium) for detoxification from benzodiazepines and a course of methadone as treatment for heroin addiction. The woman began by taking 10ml dose of methadone, to be increased to 30ml over the course of five days. The purpose of this course was to stabilise the woman's dependency before further treatment would be given.
18. The woman was seen the following day by a second prison nurse. The nurse observed that the woman was pale and tired, and the woman told her that she had not slept well. The woman had brought two inhalers to prison with her and had asked that they be prescribed. The woman also told the nurse that she suffered from depression and had taken Prozac in the community. The nurse telephoned the woman's community doctor's surgery to request details of her prescriptions. A fax was returned shortly afterwards, outlining the woman's medication as salbutamol and fluticasone propionate (medication to treat asthma) inhalers, adalat (to treat high blood pressure) and Prozac. These medications were prescribed to the woman through the prison pharmacy the same day.
19. On 10 March, the woman was seen by another prison doctor. The woman spoke about her pregnancy and requested a termination, saying she had thought it through and was aware of the risks. The doctor made a referral

to a local hospital. On the same day, the woman moved from the first night centre to a cell on Waite Wing.

20. The following day, the woman was seen in the substance misuse clinic by a substance misuse nurse. (This was a standard review that all patients receive on the fifth day of a methadone programme.) The woman said that she was fine on her current dose of 30ml methadone and the nurse observed that she showed no signs of withdrawal symptoms. The nurse decided to keep the woman on her current dose of methadone in order to maintain her tolerance levels. As the woman would only be in prison for a short time the aim of her methadone programme was to ensure that, should she resume taking heroin on release, her body would be able to tolerate the drug and she would not accidentally overdose.
21. On 13 March, the woman moved from Waite wing to Barker House, one of the small villas. An officer noted in her wing record that the woman was polite and had no problems. Six days later, the gynaecology department at the Wythenshawe Hospital contacted Styal, following the prison doctor's referral, to say that the woman was too advanced in her pregnancy to qualify for their services. A referral was therefore sent to the Whitworth clinic at St Mary's Hospital, Manchester. They replied the following day, having arranged an outpatient appointment at the South Manchester Hospital on 27 March.
22. The woman was seen by a third prison nurse on 21 March, after reporting swelling in her right leg. After examining the woman, the nurse advised her to elevate and rest her leg. The woman also said that the Prozac was making her feel unwell. The nurse made an appointment for the woman to see a prison doctor.
23. Six days later, the woman attended her outpatient appointment at South Manchester Hospital. On 29 March, she saw a prison doctor regarding her Prozac. The woman told the doctor that she had stopped taking it a week earlier as it made her feel unwell. The prison doctor noted that the woman was experiencing excessive anxiety and her symptoms were worsening. The woman asked for a change to her medication. The prison doctor agreed, and prescribed a course of citalopram (which is used to treat depression).
24. Having made an application for a nurse assessment, the woman was seen by a triage nurse, on 4 April. The woman said that she had been suffering a cough for two weeks and had itchy and cracked skin on her hands and arms. The woman added that she suffered from Raynaud's phenomenon (narrowing of the arteries supplying blood to the hands, resulting in cold, white fingers and pins and needles). The triage nurse made an appointment with a prison doctor.
25. The woman was assessed the following day by another prison doctor. She told the doctor that she had been coughing and producing green sputum for two weeks. The doctor noted that the woman was asthmatic

- and smoked 20 cigarettes a day. He examined the woman and observed that her throat was clear but she had experienced some wheezing in her chest. The doctor prescribed a course of amoxicillin (an antibiotic), plus hydrocortisone cream for the woman's skin complaint.
26. Two days later, the woman was reviewed by the same doctor she had seen on 10 March. The woman was still low in mood and the prison doctor therefore increased her dose of citalopram. On 9 April, the woman attended the Whitworth clinic at St Mary's Hospital for a consultation in advance of her termination. Appointments were booked for 12 and 14 April for the two stages of her termination. The woman was seen by a nurse the same day and said that she was feeling drained and emotional. She was allowed to rest in her house for a day rather than go to work.
 27. On 10 April, a fax was sent from the Offender Management Team at Styal to the probation office in Fleetwood, Lancashire. The woman's eligibility date for release under the Home Detention Curfew Scheme (HDC, commonly known as electronic tagging) was 3 May. The fax asked the Lancashire Probation Area to comment on the woman's suitability for release on HDC to an address that she had supplied a week earlier. The Probation Service was asked to reply by 24 April. No reply had been received at the time of the woman's death.
 28. The woman subsequently went to the Whitworth clinic on 12 and 14 April for her termination. She was next seen by healthcare staff at Styal on 16 April for a stop smoking clinic. After the clinic, the woman started using nicotine patches. The following day she returned to healthcare for a hepatitis B vaccination. On 22 April, the woman was given two days house rest by a healthcare assistant after the woman said that she was feeling uncomfortable and unhappy following her termination.
 29. Five days later, the woman complained of toothache and was given paracetamol at the treatment hatch in healthcare. On 30 April, she submitted a healthcare application form saying, "I need an appointment for nurse assessment and substance misuse." On each of the following three days, the woman again collected paracetamol for toothache.
 30. My investigator spoke to the woman's room-mate who said that the woman had been "struggling with her breathing" for around a week and a half before she died. She said that this happened mainly at night, when the woman would wake up coughing, and that it got worse over the course of the week. The woman also began to struggle when climbing stairs. However, her room-mate did not think that the woman reported any of these symptoms to healthcare staff.
 31. On 5 May, the woman was seen by the nurse at the substance misuse clinic. The woman spoke about her termination and was observed by the substance misuse nurse to be emotional, tearful and low in mood. She told the substance misuse nurse that she had not been eating or sleeping and said that she "felt like being dead". The woman also said that she

had stopped taking citalopram a week previously as she felt that it was “making her worse”. The substance misuse nurse told my investigator that the woman showed no signs of struggling for breath and that she did not speak about breathing difficulties.

32. As a result of the woman’s low mood, the substance misuse nurse opened an Assessment, Care in Custody and Teamwork form (ACCT, the form used by the Prison Service to monitor and support prisoners at risk of suicide or self-harm). At around 4.45pm, the woman attended an ACCT case review with a Senior Officer (SO) and a prison officer, followed by an assessment interview with the prison officer. The SO made the following observation:

“The woman has many issues at present including a recent termination. The woman has stopped taking her medication as she felt it was making her more depressed. Also struggling with the speed at which she is being reduced from her diazepam. The woman has never self-harmed and has no thoughts of suicide or self-harm ... Happy to remain on Barker with supportive friends.”

33. In addition, the prison officer told my investigator that the woman showed no signs of any physical symptoms nor of difficulty breathing and that she did not appear to be agitated. He and the SO decided on the level of ACCT monitoring. The woman would be observed on four occasions during the day and night, and staff should have three meaningful conversations with her. The monitoring would remain in place until the woman’s first scheduled ACCT review on 14 May. They also requested an appointment for the woman to see a prison doctor to discuss her medication.
34. The following morning, the woman was seen at roll check (a count of all the prisoners) at around 7.50am by her personal officer. (Each woman is assigned an officer who they can go to first with any problems.) The woman told the personal officer that she was “okay”. At around 9.00am, the woman left the house to go to the kitchens where she had been working as a dish washer for around two weeks. From around 11.30am to 1.30pm, the woman returned to Barker House for lunch. She told her personal officer that she felt “fine”.
35. In interview, the substance misuse nurse recalled seeing the woman around lunchtime on 6 May. She remembered that the woman was outside with some other women. The woman called the nurse over and said that she had not been seen by the triage clinic. The substance misuse nurse then went to the healthcare centre and arranged an appointment for the woman for the following day.
36. Later that afternoon, the woman was taken ill in the kitchen. At afternoon break, the women had asked if the door could be opened because it was a hot day and very stuffy in the kitchen. A member of staff who works in the kitchen told my investigator that the woman was “breathing heavily

because of the heat". The staff kitchen worker said that her breathing was not so heavy to the extent that the woman had difficulty breathing and so she was not alarmed or worried.

37. The staff kitchen worker was told by one of the other women that the woman did not have an inhaler. She therefore took the woman to Nightingale House where she borrowed another woman's inhaler. After taking some breaths from the inhaler, the woman told the staff kitchen worker that she was "alright". The staff kitchen worker advised the woman to get an inhaler from healthcare that night. Her medical record indicates that the woman received a new salbutamol inhaler on 6 May, although it is not certain when she received it.
38. At 7.30pm that evening, an officer noted in the woman's ACCT document that he had seen her at roll check and she had said she was "okay". Her room-mate said that the woman was no worse than normal that evening. At 10.30pm, two officers visited the woman for her first ACCT check of the night. The first officer noted that the woman was "lying in bed watching TV, states fine when asked". The two officers returned at 1.05am. On this occasion it was the second officer who made the entry. He noted that he had spoken to the woman and there were "no concerns". At interview with my investigator, the second officer recalled that the woman "wasn't wheezing or anything like that at all".
39. At around 3.30am, the woman woke her room-mate and told her that she was struggling to breathe. Her room-mate pressed a call bell on the landing to alert staff to attend. When she returned to the room, the woman was sitting on the edge of her bed and leaning over. The woman then used her inhaler. At around 3.34am, the woman's room-mate pressed an alarm bell, alerting staff that urgent assistance was required.
40. At the same time, the second officer and a third prison officer arrived at Barker House and made their way up to the woman's room. The second officer said that they found the woman "really struggling to breathe". He ran to the first night centre, where the response nurse is based overnight, for assistance. The officer explained that he went for the nurse rather than using the radio because the first night centre is just 50 yards from Barker House and he would have had to go there anyway to escort the nurse. (Nurses at Styal do not carry keys at night-time and so they have to be escorted around the prison at night.)
41. As the officer was making his way to the first night centre, an SO and another officer arrived at Barker House. The SO was orderly officer that night, meaning that she was the most senior officer on duty and therefore in charge of the prison. In interview, the orderly officer said that she found the woman sitting on her bed having difficulty breathing. The response nurse then arrived. The response nurse gave the woman an oxygen mask to help her breathe.

42. The response nurse asked the staff to make sure that the woman continued to take oxygen and radioed her colleague (who was based on Waite wing overnight) to come to Barker House to assist. She then went to the healthcare centre to collect a nebuliser (a device similar to an inhaler which is used to treat severe asthma attacks). The response nurse told my investigator that she opted to fetch the nebuliser herself because the officers do not hold a medical suite key and because she knew where to find the device. She said that it took her around three or four minutes to collect the nebuliser and return to Barker House.
43. The orderly officer said she saw the woman's hand turn blue whilst the response nurse was collecting the nebuliser. She checked for a pulse and said that she could feel "something moving". There was also foam coming out of the woman's mouth. The orderly officer radioed the control room to request an ambulance. The time was now 3.45am.
44. Shortly afterwards, the response nurse returned to Barker House and, on seeing the woman, realised she had entered cardiac arrest (her heart had stopped beating). She and the healthcare nurse, who arrived at around the same time, immediately began cardiopulmonary resuscitation (CPR). The healthcare nurse also radioed a healthcare assistant and asked her to bring a defibrillator from the healthcare centre. The healthcare assistant, who was based on Waite wing overnight, arrived with the defibrillator around four minutes later. The nurse attached the defibrillator which instructed that she apply two shocks to the woman. After this, the nursing staff continued to apply CPR until the paramedics arrived at around 3.55am.
45. At around 4.25am, the woman was taken to Wythenshawe Hospital by ambulance. The nurse travelled with her and continued to apply CPR in the ambulance with the help of a paramedic. The woman was pronounced dead at 4.58am by a hospital doctor. A post mortem examination later determined the cause of death to be acute asthma.
46. At around 6.00am, the duty governor (the on-call senior manager) telephoned the woman's parents to break the news of her death to them. The duty governor said that he broke the news over the telephone rather than in person on the instructions of the Governor. This was because of the distance that the woman's parents live from the prison, which is around 60 miles.
47. The woman's funeral was held on 16 May. My investigator found that the prison's contribution to the funeral arrangements was in accordance with PSO 2710 (the Prison Service Order that sets out the actions to be taken following a death in custody).
48. Around a week after the woman died, a Principal Officer (PO) reported to the performance manager at Styal that she had overheard one of the officers who responded when the woman was taken ill telling someone that the response nurse had been asleep when the Officer had run to get

her assistance. The officer was based on the first night centre with the response nurse. The PO later told my investigator:

“It transpired during the course of the [overheard] conversation that the nurse may have been asleep on the first night centre without her boots on and without her belt on.”

49. At interview with my investigator, the officer said that she was “there at the time but to be honest I wasn’t really watching what the response nurse was doing”. After reading a copy of the interview transcript, the officer retracted this and said that “[the response nurse] did have her belt and shoes off, but was not asleep”. The other officer said that the response nurse was sitting on the sofa watching television. He added that he did not see whether she was wearing her shoes or belt. The response nurse told my investigator that she was lying on the sofa with her shoes off and belt undone. She said that she was not asleep.

50. The response nurse was suspended from duty following this allegation. An investigation into her conduct was undertaken by a reviewer on behalf of the local Primary Care Trust. The investigation concluded that:

“The response nurse was ‘resting’ with her shoes removed, watching television in the sitting room of [the first night centre]. She was not asleep ... It is not certain whether the response nurse’s belt was loosened, undone about her person, or removed.”

51. The investigation recommended that no formal disciplinary action should be taken against the response nurse and that her suspension from duty should be lifted.

ISSUES

Retrieving information from the community doctor

52. In his clinical review, the clinical reviewer notes that the woman had a long history of poorly controlled asthma and that her peak flow (a measurement of how well the lungs are working) was around half that expected for a person of her age. In 2006, the woman attended Accident and Emergency following a severe asthma attack and she regularly attended her community doctor's surgery when she needed treatment.
53. During the woman's reception health screen at Styal, she identified a number of health problems including asthma. She also requested a termination of pregnancy and was treated for substance misuse. It is those two issues that dominated her healthcare at Styal, particularly during her first six weeks of imprisonment. Given that the termination and substance misuse were issues that had to be dealt with immediately, I believe that their priority is understandable.
54. However, this meant that the seriousness of the woman's asthma was never determined by prison healthcare staff. The woman herself did not reveal her history of poorly controlled asthma. I am unable to say why this was, although it is clear that the woman had a lot on her mind when she was in prison. On the woman's second day in prison, her community doctor's surgery was contacted to confirm the medication that she was taking. They were not, however, asked to provide the woman's full medical records. Prison Service Order (PSO) 3050 instructs that:
- “When a prisoner enters reception ... efforts should be made to retrieve any information required from the prisoner's GP or other relevant service he/she has recently been in contact with.”
55. The former healthcare manager at Styal told my investigator that it is the responsibility of healthcare staff on the first night centre to obtain doctor's records after obtaining the woman's consent. However, she went on to say that they do not have enough resources to staff the first night centre and so this is not always carried out.
56. The clinical reviewer makes the following comment in his clinical review:
- “Ideally all prisoners should have a medical summary from their General Practice. It is recognised that this is problematic given the high throughput in the prison. In this instance it is not clear that possession of the records would have made a major difference in the way [the woman] was managed.”
57. In the woman's case, a lack of resources did not prevent her medical records being requested from her doctor's surgery. This could have been done at the same time that the surgery was asked to confirm her medication. I note the clinical reviewer's comment that it is not clear if the

records would have made any difference to the way the woman's medical needs were managed at Styal. My view is that it can only be beneficial for healthcare staff to have full access to the details of a patient's medical history.

The Head of Healthcare should remind staff to request community GP records for all new arrivals in prison who report a chronic disease in their medical history.

Chronic disease management

58. The woman's room-mate told my investigator that the woman had been "struggling with her breathing" for around a week and a half before she died. Her room-mate did not think that the woman reported her symptoms to healthcare staff. The clinical reviewer makes the following comment:

"In retrospect this was a very severe asthma attack. It would appear that the woman was not aware how seriously ill she was becoming. It is possible that she was preoccupied by depressive symptoms associated with her termination and preparation for her imminent release. In the words of a respiratory physician, 'people with poorly controlled asthma quite frequently have become so accustomed to continual breathlessness that they fail to recognise when they are deteriorating abnormally'."

59. At the time of the woman's death there were no chronic disease clinics at Styal. Regular attendance at such a clinic would give asthma sufferers the opportunity to talk about and educate themselves about their condition. It would also provide a regular opportunity to review a patient's medication and treatment.

60. As noted earlier, in her inspection report published in February 2009, HM Chief Inspector of Prisons made the following recommendation:

"Chronic disease management should be improved and women should be seen regularly with support from community nurse specialists."

61. I am pleased to note that the prison provided the following response to this recommendation, which is to be completed by December 2009:

"Service delivery options are being explored and we await the result of a bid for a specialist respiratory nurse."

I trust that the tragic lessons of the woman's untimely death will add emphasis to the decisions about chronic disease clinics.

Events of 6 May 2008

62. As I have noted in paragraphs 39-40, the woman was taken ill in the kitchens on the afternoon of 6 May. She was said to be "breathing heavily

because of the heat” and required the use of an inhaler. The member of kitchen staff who helped her said that she felt that it was quicker to get the woman an inhaler from a nearby house than it was to take her to healthcare.

63. None of the prison staff in the kitchen was aware at the time that the woman was asthmatic. The staff kitchen worker told my investigator that they now ask any woman who is interviewed for a job in the kitchen whether they have any health concerns that staff should know about.
64. The staff kitchen worker said that, with hindsight, she worried whether she should have taken the woman to healthcare. At the time she did not consider that the woman’s symptoms were sufficient. It should also be noted that the woman did not ask to see a nurse either. Nevertheless, it would be advisable in future to inform healthcare staff if a woman is taken ill so that they can decide whether further assessment is necessary. This would also ensure that a record is kept of the events for future reference. It is also worth noting that it is not appropriate for one prisoner to take medication prescribed to another.

The Governor should remind staff to inform healthcare whenever a prisoner is taken ill in their place of work.

65. There was speculation that the woman had not had her own inhaler for some time before she died. The staff kitchen worker told my investigator that she had to take the woman to Nightingale House to borrow another woman’s inhaler, as she was told that the woman did not have one of her own. The staff kitchen worker advised the woman to go to healthcare that evening to get a new inhaler.
66. The woman’s room-mate was interviewed twice by my investigator. On the first occasion, she said that the woman had been using her inhaler a lot more in the week before she died. However, at the second interview, she said that the woman had gone for some time without an inhaler, possibly a week or two. It does not appear that the woman spoke about this to any of the staff whom she saw on 5 May for her substance misuse clinic or ACCT interviews. Indeed, both the substance misuse nurse and the ACCT officer told my investigator that there was no sign that the woman was struggling for breath when they spoke to her.
67. The staff kitchen worker told my investigator that after the woman’s death she heard some “gossip” from some of the women that the woman may have been bullied for her inhaler by other asthmatics. The woman’s room-mate was adamant that this was not the case and that the woman had not been bullied or had her inhaler taken from her. I have seen no other evidence to support the claim that the woman was bullied whilst at Styal.
68. Her prescription charts confirm that the woman received a new inhaler on 6 May. This was the third that she had received at Styal, having also

been given inhalers on 7 March and 7 April. On each occasion, the woman received a one month supply of salbutamol.

69. It is not clear when the woman received her inhaler on 6 May. Medications which prisoners hold in their own possession are normally collected at lunchtime, and her room-mate thought that this was the time that the woman picked hers up. However, this would not explain why the woman had to borrow an inhaler later that afternoon. It is possible that she had left her inhaler in her room when she went to work and that the staff kitchen worker misunderstood what she was told about the woman not having one.
70. The clinical reviewer provided the following comment on the impact on the woman's health had she gone without her inhaler for some part of the day before her death:

"In practice this is highly speculative but the salbutamol inhaler would alleviate some symptoms but would not alter the progression of the attack. Use of a steroid inhaler would help in modifying an attack if used over several days. In serious attacks the only effective treatments are prompt nebulisation, systemic steroids and a range of drugs that can only really be administered in a hospital setting."

71. I have been unable to determine whether the woman did go without an inhaler for a period before her death. It is clear that she collected a new inhaler on 6 May, although I cannot be certain when she did so. The woman was seen using her inhaler when she was taken ill during the early hours and the police confirmed that it was present in the room when it was unsealed after her death.

Emergency response

72. When the woman developed breathing difficulties in the early morning her room-mate pressed a call bell for assistance and, four minutes later, an alarm bell. At around the same time, two officers arrived at Barker House in response to the call bell. Having found the woman struggling to breathe, one of the officers went to fetch healthcare assistance immediately. He told my investigator that he ran to the first night centre, where the response nurse was based, rather than using a radio. This was because nursing staff have to be escorted around the prison at night as they do not carry a full set of keys (this is a standard security procedure in prisons during night patrol state). He would therefore have had to return to the first night centre anyway to escort the response nurse. The officer added that the first night centre is just 50 yards from Barker House, so it did not take long for him to return.
73. Styal operates a code system for requesting assistance in a medical emergency. A 'code blue' call indicates that a woman has stopped breathing. It would apply to the woman's circumstances as she was,

according to the officer who fetched assistance, “really struggling to breathe” when he went for assistance.

74. The clinical reviewer makes the following comment regarding the emergency response:

“[The woman] was already very seriously ill at the time the prison staff were called. In attacks of this nature resuscitation outside of a hospital is near impossible as the lungs are clogged with thick mucous plugs. I discussed the issue of earlier intervention with the Respiratory Team at East Cheshire NHS Trust. Successful treatment would necessitate at least two nebulisations using a combination of drugs. Treatment would need to have been initiated about 20 minutes before the arrest occurred so realistically the guards would have needed to have been called 15-20 minutes earlier. Treatment must be initiated before the lungs have become totally obstructed as the aerosol that loosens the mucous will not penetrate otherwise. Ideally, in severe attacks treatment and monitoring should take place in a unit with rapid access to intensive care.”

75. Had the officer radioed a ‘code blue’ call for assistance before leaving Barker House, the response nurse might have been ready to return with him as soon as he arrived at the first night centre. It is clear from the clinical reviewer’s assessment that saving a few seconds in these circumstances would not have made a difference to the final outcome. However, there might be occasions in the future when such intervention could be crucial.

The Governor should remind staff of the importance of using the radio code system to request urgent assistance from the response nurse.

76. Around a week after the woman died, an allegation was made that the response nurse was asleep when the officer requested her assistance. An officer was in the first night centre at the time, was overheard telling colleagues that this might have been the case. The officer later told my investigator that the response nurse “did have her belt and shoes off but was not asleep.” The officer who went to fetch the nurse said that she was sitting on the sofa watching television and he could not see whether she was wearing her shoes or belt. The response nurse herself said that she was lying on the sofa with her shoes off and belt undone, but was not asleep.
77. The response nurse was suspended from duty following this allegation. An investigation into her conduct was carried out on behalf of the local Primary Care Trust. The investigation concluded that the response nurse was “resting with her shoes removed. She was not asleep.” She went on to say that “it is not certain whether the response nurse’s belt was loosened, undone about her person, or removed.” The investigator

recommended that no formal disciplinary action should be taken against the response nurse and that her suspension from duty be lifted.

78. I am unable to say from my own investigation whether the response nurse was asleep or not. By her own admission, she had removed her shoes and undone her belt. As I have noted in paragraphs 77-78, a short delay in attending to the woman would not have made a difference to the final outcome. However, it is clearly unacceptable that the response nurse was not in a position to respond immediately to the emergency.

The Governor should remind all night staff of the importance of being able to respond to an emergency situation at all times.

79. After attending to the woman and giving her oxygen, the response nurse went to the healthcare centre to collect a nebuliser. She told my investigator that she went to collect it herself because the officers do not carry a key for the medical suite and would not know where to find the equipment. Shortly afterwards, when the woman went into cardiac arrest, a healthcare assistant was asked to collect the emergency bag and defibrillator from the healthcare centre.
80. The response nurse requested the healthcare nurse's assistance at around the same time that she went to collect the nebuliser. It might have been better if she had remained with the woman and asked the healthcare nurse to collect the equipment on her way to Barker House.
81. As there are no inpatient facilities at Styal, no staff work in the healthcare centre at night. The response nurse is based on the first night centre. It is puzzling that emergency equipment is locked in an empty building, separate to the response nurse.

The Head of Healthcare should arrange for emergency equipment to be moved to the first night centre during night patrol state.

Home Detention Curfew

82. Having begun a term of 33 weeks imprisonment on 6 March 2008, the woman was eligible for release on Home Detention Curfew (HDC) on 3 May, eight weeks and two days after her arrival at Styal. PSO 6700 provides the following instruction to prisons regarding when to start the process of assessing whether a prisoner is suitable for release on HDC:

“The risk assessment for Home Detention Curfew must where possible be commenced ten weeks before a prisoner's eligibility date. In cases where the prisoner is not sentenced until there are less than ten weeks to go until their conditional or automatic release date, the assessment must be commenced immediately ... arrangements must be made therefore to request [the necessary] information immediately upon reception.”

83. The PSO also provides a timetable for completing the assessment process for HDC. Ten weeks before the eligibility date (so “immediately upon reception” in the woman’s case), the prisoner must complete a form giving details of their proposed release address. The woman signed this form on 2 April, four weeks after she arrived at Styal and four and a half weeks before her eligibility date.
84. Eight weeks prior to the eligibility date, an assessment form must be sent to the Probation Service for completion and return within ten days. This form was faxed to the probation office in Fleetwood on 10 April, just over three weeks before the woman’s eligibility date. The form was due to be returned by 24 April. On the day of the woman’s death (three days after her eligibility date), it had still not been returned. A line manager in the custody office at Styal said he expected that they would have started to follow up the omission at around the time of the woman’s death.
85. Five weeks prior to the eligibility date, a form for comments by the prisoner’s personal officer must be completed. This was sent to Barker House on 10 April, but had also not been returned on the day of the woman’s death. The woman’s personal officer said that she had recently joined the Prison Service and was still in training at the Prison Service College on 10 April. She did not receive the form and it is not clear what happened to it after it left the custody office.
86. The woman died in custody in the early hours. Had the relevant assessments been completed on time she could have been released to her home on 3 May. I cannot say whether she might still be alive had she been released on her HDC eligibility date. However, it is the case that the woman spent the last few days of her life in prison rather than at home with her family. I do not think that the system in place to track and monitor the progress of HDC application forms is adequate. Particular importance should be given to obtaining the completed forms when the HDC date is a short time away. I am also critical of the performance of the Lancashire Probation Area.

The Governor should put systems in place to ensure that risk assessments for release on HDC are completed in accordance with the timescales set down in PSO 6700.

A copy of this report should be sent to the chief officer of the Lancashire Probation Area in view of my findings in paragraph 30 and my comments in paragraphs 85-89.

87. The Lancashire Probation Area provided the following response to my draft report:

“The first point is that we would normally expect to receive eight weeks notice of a request for HDC suitability. In this case the prison states that the form was faxed to our Fleetwood office on 10 April 2008, giving us just nine working days to complete the form.

“The more substantive point is that we have no trace of having received the fax at our Fleetwood office. I am not aware what the Prison Service policy is in relation to the transmission of restricted information. However, the National Probation Service Policy on restricted information states ‘that a fax should only be sent where a receiver is standing by the fax machine waiting for transmission. The sender should then confirm the fax has been correctly received in full’. It also states that ‘a fax should never be sent to an unattended machine’. As far as we are able to establish this did not happen in this case.

“As this was a non statutory case we would not have been expecting an HDC request. We are unable to shed light on what happened to the fax after it left the prison. We will re-visit our procedures to ensure that we have a clear record of such requests received in the future.”

Breaking the news of the woman’s death to her family

88. Prison Service Order (PSO) 2710, which provides instructions for the aftermath of a death in custody, says that Governors must:

“Arrange notification to the next-of-kin and any other person reasonably nominated by the prisoner as soon as possible in a suitable manner, giving an accurate factual account of what has happened.”

89. The accompanying Family Liaison Officer (FLO) Guidance recommends that:

“The family should be informed face to face as soon as possible after the death. Wherever possible this should be done by a dedicated Family Liaison Officer working alongside the Chaplain, or Governor or most senior individual available together with the Chaplain.”

90. The woman had notified the prison that her next of kin was her mother who lives in Blackpool, around 60 miles from Styal. At around 6.00am on the day of the incident, the woman’s parents were informed of her death over the telephone by the duty governor. The duty governor told my investigator that he broke the news over the telephone rather than in person on the instructions of the Governor, on account of the distance that the woman’s parents live from the prison.

91. The FLO guidance says that distance from the prison is a factor that should be taken into account when determining how to break the news of a death. However, I do not consider 60 miles to be a prohibitive distance and take the view that staff from Styal could and should have visited the woman’s parents in person. Even if distance was a reasonable issue, the guidance says that a FLO or chaplain from an area nearest the family home could be asked to break the news. There are a number of prisons

in the North West which are close to Blackpool, and some are within 20 miles of the town.

The Governor should ensure that, whenever reasonable, the news of a death in custody is broken to the next of kin by a member of prison staff, face to face, in accordance with national instructions.

CONCLUSION

92. The woman had a very difficult time during the two months that she spent at Styal. She had a lot of contact and support from healthcare staff regarding a variety of issues. Her termination, substance misuse, and depression were understandably seen as priority issues. It is possible that the pressure of these issues was one reason why the woman did not tell anyone that her asthma was more severe than it was thought to be.
93. My report highlights several areas in which more could perhaps have been done for the woman. I am particularly disappointed that she was still in prison several days after she could potentially have been released into the community on HDC. Nevertheless, I cannot say that the woman's death would have been prevented had she received that further support that could have been provided.

RECOMMENDATIONS

1. The Head of Healthcare should remind staff to request community GP records for all new arrivals in prison who report a chronic disease in their medical history.

Accepted – we have implemented a process which sees a proforma faxed to the individual's GP within 24 hours of their disclosure or diagnosis of a chronic condition. In addition we have appointed a respiratory nurse to address issues of this nature on site.

2. The Governor should remind staff to inform healthcare whenever a prisoner is taken ill in their place of work.

Accepted – this will be completed through issuing of notices to staff and raised at staff briefings on periodic basis.

3. The Governor should remind staff of the importance of using the radio code system to request urgent assistance from the response nurse.

Accepted – this will be addressed through the issuing of a notice to staff and inclusion in security and radio induction training.

4. The Governor should remind all night staff of the importance of being able to respond to an emergency situation at all times.

Accepted – this will be addressed through the issuing of a notice to staff and will be enforced through regular checks by night orderly officers and monthly duty governor visits.

5. The Head of Healthcare should arrange for emergency equipment to be moved to the first night centre during night patrol state.

Accepted – there is now a set of emergency response equipment and nebuliser available on the first night centre.

6. The Governor should put systems in place to ensure that risk assessments for release on HDC are completed in accordance with the timescales set down in PSO 6700.

Accepted – systems will be put in place to reduce the maximum time for the commission of HDC assessments on a woman entering Styal already in the lead in time to HDC. Our target is to ensure all assessments have been sent off within seven days of reception unless in exceptional circumstances. In addition we will introduce a system which identifies when external agencies have not responded and automatically generate a chase up of this missing documentation.

7. A copy of this report should be sent to the chief officer of the Lancashire Probation Area in view of my findings in paragraph 30 and my comments in paragraphs 85-89.

Accepted – see paragraph 90

8. The Governor should ensure that, whenever reasonable, the news of a death in custody is broken to the next of kin by a member of prison staff, face to face, in accordance with national instructions.

Accepted – this will remain our priority and will be highlighted within the contingency plans for a death in custody.