

**Investigation into the circumstances surrounding the
death of a woman in December 2009,
at Christie's Hospital,
whilst in the custody of HMP Styal**

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

August 2010

This is the report of an investigation into the circumstances surrounding the death of a woman at Christie's Hospital on 4 December 2010. She was a prisoner at HMP Styal. A post mortem recorded the cause of her death as cancer. The investigation was led by one of my colleagues.

I offer my sincere sympathy and condolences to the woman's family and friends for their loss. One of the Ombudsman's family liaison officers contacted the woman's family during the investigation process. I apologise for the delay issuing my report and any additional distress this may have caused.

I am grateful to the Governor and staff of Styal whose assistance was a great benefit to my investigator.

I thank the local Primary Care Trust for appointing of a clinical reviewer and thank him for his comprehensive report. As the woman died from natural causes, the findings of the clinical review play a pivotal role in my report. Her family would have preferred her to be nursed at home.

The review of the woman's clinical care shows that she received compassionate care and treatment equitable to what she would have received in the community.

Neither the clinical reviewer nor I make any recommendations. I recognise areas of good practice, in particular the limited use of restraints, the woman's release on temporary licence and appointing a family liaison officer when she was diagnosed as terminally ill.

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

Jane Webb
Acting Prisons and Probation Ombudsman

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SUMMARY

On arriving at HMP Styal, the woman who died told a nurse that she had been under the care of a psychiatrist for ten years and had previously been in a psychiatric hospital. She also said that she had seen her own doctor within the previous few months about problems with her knees. She had a history of diabetes, blood pressure and asthma, and was a smoker.

The woman was transferred to HMP Newhall on 5 June 2008. A nurse confirmed her medical history and medication from Styal. She had regular contact with prison doctors, nurses and members of the Mental Health In-reach Team (mental health specialist practitioners). However, she was not happy at Newhall and, at her own request, transferred back to Styal on 23 December.

On 6 January 2009, the woman complained of swelling in her neck and was referred her to the Ear, Nose and Throat (ENT) specialist at the local hospital. She was seen as an outpatient on 3 February and the consultant recorded that she had large lumps on both sides of her neck and arranged further tests.

The woman was admitted to Wythenshawe Hospital on 9 February after complaining of severe upper abdominal pain. She remained there for three weeks. She was re-admitted to hospital on 8 March, and stayed until transferring to Christie's Hospital on 15 May. The cancer specialist registrar confirmed the diagnosis of cancer. In conjunction with the hospital, prison healthcare staff put together a plan of care for her which included cycles of outpatient chemotherapy.

Once discharged from hospital the woman continued to receive the daily care at Styal as outlined by the hospital. A cancer nursing specialist visited the prison to complete an assessment and offer support and guidance to healthcare staff. Healthcare staff maintained contact with the hospital to update them on her condition and clarify treatment and medication.

The woman was re-admitted to Christie's Hospital on 2 November. She remained in hospital and her condition deteriorated rapidly. The Deputy Governor authorised her full release on temporary licence to Christie's Hospital on 20 November, and began the process of applying for compassionate release. The prison family liaison officer kept the woman's family informed of the actions the prison had taken.

The woman died in hospital on 4 December. The prison followed the guidance given in Prison Service Order (PSO) 2710, "Follow up to death in custody" when breaking the news of her death, maintaining contact with her family and offering assistance towards the funeral expenses.

I am satisfied that the care and attention she received at Styal was equitable to what she could have expected to receive in the community. I recognise the good practice in family liaison, the effective and sensitive assessment of the use of restraints and release on temporary licence.

THE INVESTIGATION PROCESS

1. My investigator obtained all the relevant records including the woman's main prison record and medical records. Notices were posted to staff and prisoners about the investigation on 4 December 2009 but no contributions were made.
2. The local Primary Care Trust asked a medical practitioner to review the woman's clinical care. I am grateful to him for undertaking this review. I requested the review within ten weeks of her death and received it on 10 June 2010. The delay receiving the review has significantly affected the timeliness of my own report.
3. My investigator contacted HM Coroner to inform him of the nature and scope of my investigation and to request a copy of the post mortem report. Upon completion, my report will be sent to the Coroner to assist his enquiries into the woman's death.
4. One of the Ombudsman's family liaison officers contacted the woman's family at the beginning of the investigation and asked if they had any questions or concerns about the care she received. The woman's family believe that she was disadvantaged in her medical treatment by being in prison because she would have been able to be nursed at home if she had been living in the community. Nevertheless, they told the family liaison officer that they were impressed with the care and support they received from staff at Styal.
5. I have attempted to address the issue raised by the family within this report and I hope that it provides a better understanding of how the woman was looked after in the time leading up to her death.

HMP STYAL

6. 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 of England and North Wales. It mainly holds women serving short sentences or those on remand. The prison has an operational capacity of 460 women.
7. Styal is made up of two types of accommodation. There is a conventional wing, Waite wing, where around 135 women live in single and shared cellular accommodation. There are also 16 Victorian villas each accommodating up to 28 women in shared rooms of two to six. 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. The woman who died lived in a single cell.
8. 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 in the prison throughout the day and night. Nursing staff are based in the first night centre during the night, as there are no inpatient facilities at the prison.
9. HM Chief Inspector of Prisons conducted a full announced inspection of the prison in September 2008. The 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.”
10. The 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.”
11. Prisons are also monitored by an Independent Monitoring Board (IMB), whose members are drawn from the local community. They have full access to each prisoner and every part of the establishment. The last available annual report by the Styal IMB covers the period 2008 to 2009. The report made the following comments regarding healthcare:

“This has been a difficult year due to the protracted commissioning and tendering process for all Healthcare services.

“There are several areas of Healthcare where the building provision is inadequate and does not comply with Standards for Health Privacy and Dignity.

“The Board is pleased to note that the use of Agency nurses is likely to be greatly reduced in the future under the new Health Care Contract, as at times this arrangement has fallen far short of prison standards.

“The waste of resources due to prisoners not attending appointments continues to be of major concern. This is a prison management issue as well and needs to be tackled jointly with Healthcare Management.

“Staff at Styal is a highly motivated team of professionals. The Board acknowledges the high level of care they provide to the prisoners in their care.”

12. The woman’s death was the eighth to have occurred at Styal since April 2004, when the Ombudsman began investigating deaths in prison custody in England and Wales. Her death was the third due to natural causes. There are no similarities between the issues addressed in the previous investigations.

KEY FINDINGS

13. The woman who died lived with her teenage daughter. She had a history of mental illness, diabetes, asthma and blood pressure. She smoked and had a history of illicit drug use.
14. The woman was convicted of wounding with intent and sentenced to three years and ten months imprisonment on 12 May 2008. She was sent to HMP Styal where a nurse conducted an initial healthscreen check. The woman told the nurse that she had been under the care of a psychiatrist for ten years and named her current psychiatrist. She had previously been in a psychiatric hospital. She also told the nurse that she had seen her general practitioner within the previous few months regarding problems with her knees. She confirmed her medical history to the reception nurse.
15. The nurse recorded that the woman's prescribed medication was tramadol (for anxiety), citalopram (anti-depressant medication), irbesartan (for blood pressure), bendroflumethiazide (also for blood pressure), amlodipine (another blood pressure medication), simvastatin (to reduce cholesterol), levothyroxine (for an underactive thyroid), Seretide inhaler (for asthma), salbutamol inhaler (also for asthma) and metformin (for diabetes).
16. The nurse also recorded that her weight was 120kg and her blood pressure was 135/94 with a pulse of 90. (The normal range for blood pressure is 100/70 to 140/90, although the pressure varies throughout the day depending on the individual's activities. A blood pressure reading of greater than 140/90 is classed as high and a reading of 90/60 or below is classed as low.)
17. Later that same day a prison doctor saw the woman and confirmed her medical history. In response to routine questions, the doctor noted that she was allergic to penicillin, did not depend on alcohol and was not thinking about harming herself. She told the doctor that she had not taken illicit drugs for two years.
18. A nurse attempted to contact the woman's current psychiatrist by telephone on 16 May, but was advised that no one was available and to call back the following Monday. The nurse spoke to his secretary on 19 May to obtain the necessary information to assist healthcare staff at Styal to plan the care that the woman required.
19. A member of the Mental Health In-Reach Team (MHIT) assessed the woman on 28 May. She recorded that the woman's mood was a little low and she appeared anxious. She was worried about her daughter who was due to start at university. She said that she had built up a good rapport with her psychiatrist over a number of years. She said that she had fleeting thoughts of harming herself but had no intention of acting on them.
20. The woman transferred to HMP Newhall on 5 June. On arrival she was seen by a nurse who confirmed her medical history and the medication prescribed at Styal. The nurse assessed her as fit to live on a normal prison wing and go

to work. She could be in a single or shared cell (a cell sharing risk assessment is completed which considers the level of risk to the prisoner themselves or to others). The next day a prison doctor confirmed and authorised the prescribed medication that she had taken at Styal.

21. The woman was not happy at Newhall and asked to transfer back to Styal. This request was agreed, but she had to remain at Newhall until 23 December due to prisoner numbers. During her time at Newhall the woman had regular contact with the prison doctors, nurses and members of the MHIT.
22. On 23 December, she transferred back to Styal. A nurse conducted the healthscreen check to confirm her medical history and current medication, which she brought with her from Newhall. The nurse recorded that her blood pressure was 103/74 with a pulse of 83, and her weight was 107kg. A prison doctor saw her later that afternoon and authorised that the medication should continue.
23. Two weeks later, on 6 January 2009 the prison doctor who saw the woman on her return to Styal saw the woman as she complained of swelling in her neck. The doctor recorded that there was no light headedness nor voice disturbance. He referred her to the Ear, Nose and Throat (ENT) specialist at the local hospital.
24. On 22 January, the woman saw another prison doctor as she had complained of not hearing well and experienced pain in her knees. The doctor recorded that the woman was unable to hear fingers being rubbed together, and that she had a history of osteoarthritis. The doctor referred her to the local hospital to see both the orthopaedic and ENT specialists. Healthcare staff contacted a local hospital to establish when she would have an appointment following the doctor who saw her on arrival back to Styal's referral. The hospital confirmed that this would be in February.
25. The woman saw another prison doctor on 2 February as she experienced post menopausal bleeding and upper abdominal pain. The doctor recorded that she no longer had hot flushes and usually had no pain. The doctor made a gynaecological referral to the local hospital.
26. The next day the woman was taken to the local hospital for her outpatient appointment with a Clinical Fellow in ENT surgery. He recorded that she had large lumps on both sides of her neck. On examination he found that the lumps were not particularly tender but moved when she swallowed. He arranged for her to have an ultrasound scan of her neck and a magnetic resonance imaging scan (MRI) (a technique that gives a detailed picture of the inside of the body, used to diagnose conditions that affect organs, tissue and bone).
27. Two days later the woman saw the prison doctor who saw her regarding her hearing and knee pain as she complained of continued upper abdominal pain. She told the doctor that she experienced pain and stomach cramps on eating,

as well as a burning sensation afterwards. The doctor prescribed mebeverine hydrochloride (for abdominal cramps).

28. On 9 February, the woman saw the prison doctor the she had seen on 2 February as she still had abdominal pain and had vomited on several occasions. The doctor recorded that she had a high temperature and, given her recent history, arranged for her to be admitted immediately to hospital.
29. The woman was admitted to the local hospital that day. A bedwatch risk assessment was completed to assess the level of restraint, the number of escorting officers and other security issues. She was accompanied by two officers, using a long escort chain (a two metre chain with a single cuff at either end) which would be removed when she was being treated. She remained in hospital for three weeks. She had numerous tests and her family visited. The escort officers maintained daily contact with the prison to provide an update on her condition.
30. On 27 February a hospital consultant saw the woman to explain the test results and further treatment. At the woman's request, her sister was present. The consultant told the woman that the results of the tests could take seven to ten days, and she would be re-admitted to hospital once they had been received. The consultant was happy for her to return to Styal until coming back to hospital. She returned to the prison later that day.
31. The woman was taken back into hospital on 8 March. Again a bedwatch risk assessment was completed which authorised the same level of security. Escort officers kept the prison informed daily of her condition and also healthcare staff maintained contact with the hospital.
32. The hospital consultant wrote to the Governor at Styal on 25 March. He wrote that, in his opinion, the woman had cancer of the pancreas and it was highly probable that she would require continued hospital care. The consultant asked the Governor to consider easing the visiting and telephone restrictions that were in place. Following receipt of this letter a further risk assessment was completed and all the restraints were removed, although the escort officers remained. Visits were allowed subject to security searches.
33. The woman continued to be treated in hospital. A further risk assessment was completed on 24 April which reduced the level of escort to one officer. Three days later she was released on temporary licence (ROTL). The ROTL allowed her to be temporarily released from custody to the care of the hospital, and no escort or restraints were required. On 15 May, she transferred to another hospital.
34. Three days later on 18 May a specialist registrar saw the woman. He told her that a diagnosis of diffuse large B-cell lymphoma (cancer originating in the lymph nodes) had been confirmed. Her plan of care included eight cycles of outpatient chemotherapy treatment. On discharge from hospital she was prescribed the following medication:

- amitryptiline (an antidepressant)
 - omeprazole (for gastric conditions)
 - lignocaine (strong pain relief)
 - zopiclone (for insomnia)
 - levothyroxine
 - allopurinol (for excess uric acid in the blood)
 - metformin
 - citalopram
 - oxycontin (for severe pain relief)
 - docusate sodium (for constipation).
35. A nurse from healthcare at Styal visited the woman in hospital on 22 May. The nurse carried out a full assessment to ensure that her needs would be met and a care plan was put in place on her discharge from hospital. The care plan included providing her with a carer from the Primary Care Trust.
36. The woman was discharged from hospital back to Styal on 2 June. At her request she returned to her cell so she could be close to friends and healthcare staff monitored her regularly throughout the day. She continued to receive the daily care as outlined by the hospital. In addition a MacMillan cancer nursing specialist visited the prison a week later on 9 June to complete an assessment and offer support and guidance to healthcare staff. Healthcare staff maintained contact with the hospital to update them on her condition and clarify treatment and medication.
37. Between 2 June and 22 October, the woman attended hospital for her scheduled outpatient chemotherapy treatment. On each occasion the prison risk assessment authorised that the woman could be accompanied by one escort officer and no restraints were required.
38. On 22 October, she complained of severe abdominal pain that she had not experienced before. Another prison doctor saw the woman and recorded that she was doubled over in pain, looked unwell and was vomiting small amounts of fluid. The doctor prescribed a double dose of pain relief and said that he would review her within one hour. The doctor conducted the review 40 minutes later and, as there was no improvement, called for an emergency ambulance. The paramedics arrived and, as they were not allowed to take patients directly to the hospital she had previously been at, instead took her to another local hospital.
39. A new risk assessment was completed and, due to her condition, a single officer escorted her with no restraints used. She remained in hospital for seven days. During this time prison healthcare staff maintained contact with the hospital for updates on her condition. The hospital staff confirmed that she had a further scan. She was given additional pain relief following advice from the other hospital, who had seen her within a few days of admission. She was also seen by a physiotherapist who assessed that no further treatment was required as she was able to walk, wash and dress herself.

40. The woman returned to Styal on 29 October and her care continued. Four days later she attended the local hospital for the arranged outpatient appointment. Following examination and confirmation of the scan undertaken at the hospital she had recently been admitted to, the decision was taken to admit her to hospital as she was expected to deteriorate. A risk assessment was completed and the single officer remained in place with no restraints in place.
41. The prison doctor, who saw her regarding her hearing and knee pain, contacted the local hospital on 10 November to obtain an update on her condition. A hospital doctor told him that she had deteriorated. The cancer had spread to her liver and possibly the brain, and confirmed that it was unlikely that she would return to the prison.
42. Styal received a letter from the local hospital on 13 November, which confirmed that her prognosis was very poor and her life expectancy limited to a few months.
43. On 20 November, the Deputy Governor authorised the woman full ROTL, which meant that she was placed into the care of the local hospital with no further supervision from the Prison Service. A governor was appointed as the prison's family liaison officer. He informed the woman that the prison had started the process for early compassionate release from custody. The governor liaised with her family to ensure that they were aware of the actions being taken.
44. Senior managers at Styal had collated and completed the required documentation for her compassionate release application and forwarded it to the Ministry of Justice for consideration on 25 November.
45. The doctor who saw the woman regarding her hearing and knee pain contacted the local hospital on 27 November to obtain an update on her condition. The doctor was told that her condition had deteriorated rapidly and no further chemotherapy would be offered. She was too poorly to transfer to a hospice and the likely outcome was that she would die within two weeks.
46. Four days later the doctor again contacted the local hospital and spoke with the hospital doctor he had spoken to on 10 November. The hospital doctor said that the woman had been placed on the care for the dying pathway (a plan of care for people in the final stages of a terminal illness), and would remain under the care of staff at the hospital until she passed away.
47. On 4 December, the local hospital contacted Styal to inform them that the woman had died at 1.30am. The prison family liaison officer maintained contact with the family and offered assistance towards the cost of the funeral expenses.

ISSUES

Clinical care

48. Both the clinical reviewer and I are satisfied that the care the woman received was equitable to what she could have expected in the community. The clinical review makes the following comments regarding her clinical care:

“It is unarguable that the woman received a level and standard of care at HMP Styal which would be considered to be equivalent to the standard of care which she would have received had she consulted a relevant healthcare professional in the community.

“From the evidence available to me at admission to HMP Styal she did not have any symptoms or signs, the investigation of which could have led to an earlier diagnosis.

“The record shows that care was delivered to the woman in a well planned and co-ordinated manner.

“My view is that plans to meet her healthcare needs were sufficiently comprehensive and robust.

“It is also clear that there was good communication between the healthcare team at HMP Styal and the local hospital.

“I am able to say that the woman received care and treatment of a good standard at HMP Styal. She was referred to hospital in a timely manner on a number of occasions and her symptoms following the diagnosis of her tumour were managed in a competent and compassionate manner. She also was supported by Macmillan nurses. All her visits to the local hospital were facilitated.”

I am pleased that the prison made all the arrangements necessary for the woman to receive the specialist care that she required.

Use of restraints and release on temporary licence

49. Unfortunately there have been too many reports in which the Ombudsman has criticised the use of restraints when prisoners are in hospital outside of the prison. It is pleasing therefore to recognise the good practice adopted by Styal. I believe that staff effectively and sensitively assessed the use of restraints and put minimum levels in place. The woman's release on temporary licence ensured that she was treated with dignity and respect during her last days.

Family liaison

50. I also recognise the work of the governor who was appointed as the prison's family liaison officer when the woman was diagnosed as terminally ill. By appointing a family liaison officer to keep in touch with her family at the end of her life, I believe that the prison exceeded the guidance given in PSO 2710, "Follow up to death in custody". It is good practice for family liaison officers to be appointed for the families of all terminally ill prisoners and I commend Styal for their initiative. The woman's family told my family liaison officer that they were very impressed with the support given by the prison.

CONCLUSION

51. During her time at Styal, the woman had regular contact with healthcare staff and doctors which was well documented. I believe that the care she received was of a good standard and was well co-ordinated with the hospital. I judge that it was equitable to what she could have expected in the community. The clinical review confirms that her medical treatment was appropriate and that her death could not have been prevented.
52. I recognise the good practice adopted by Styal in the effective and sensitive assessment of the use of restraints and the use of temporary release on licence.

At the consultation stage of the report the woman's family wished it noted within the report that both them and the woman who died found the use of restraints on her upsetting for them and feel the report does not reflect how difficult this had been for them all. The family also wish it noted that it is their opinion that the prison did not have the facilities to treat her and although some members of staff tried their best her treatment and pain relief could not be managed within the prison setting.