

**Investigation into the circumstances surrounding the
death of a woman
in March 2010 at outside hospital,
while in the custody of HMP & YOI Styal**

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

January 2011

This is the report of the investigation into the death of a woman who died in March 2010 at outside hospital while in the custody of HMP & YOI Styal. She was 42 years old. I extend my sincere condolences to her family and friends.

The investigation was undertaken by two of my investigators. Her Majesty's Coroner for Cheshire held a post mortem into the woman's death, which found that she died of natural causes, as a result of irregular heartbeat. Further examination of the woman's heart, by specialists at outside hospital, noted that the woman was a victim of Sudden Adult Death Syndrome (SAD). This affects up to 500 young adults per year.

The woman had a history of intravenous drug misuse, alcohol and self harm. For two days, 18 and 20 March, she was taken to outside hospital for heart related problems and discharged herself back to Styal. During the early hours of a day in March 2010, the woman was found collapsed in her cell and an emergency ambulance was called. Members of healthcare staff attended to the woman with cardio pulmonary resuscitation (CPR). She was escorted to hospital and her death was confirmed by hospital staff at 4.48am.

A review of the woman's healthcare was commissioned with Eastern Cheshire Primary Care Trust (PCT). I am grateful to the clinical reviewer for carrying out that comprehensive review. I would like to thank the Governor of Styal and his staff for their help and assistance with this investigation. I would also like to thank the liaison officer for her assistance.

I endorse one recommendation made by the clinical reviewer to the PCT and the Prison Health Partnership Board that relates to the woman's clinical care. I also make my own recommendation for the Governor to review systems whereby relatives can raise concerns about prisoners.

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

January 2011

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SUMMARY

The woman was sentenced to 12 years imprisonment in 2002 for conspiracy to supply drugs. She served three years of her sentence, before absconding from HMP Askham Grange on 22 September 2005, and returned to custody three and a half years later, on 20 March 2009.

On her arrival at HMP Styal it was recorded that the woman had a history of intravenous drug and alcohol misuse and chest pain. She had attempted suicide during her previous custodial sentence. Her blood pressure reading was above the normal range. She was assessed by a doctor who prescribed a stabilising programme of methadone, along with Librium to help her cope with withdrawal symptoms.

Nine days later, officers started the Assessment, Care in Custody and Teamwork (ACCT) procedures for the woman. (The ACCT procedures are used by prison staff to identify, assess and support prisoners at risk of suicide or self-harm.) She was assessed to be at risk whilst she was detoxifying and because she spoke of personal problems. The ACCT was closed five months later, when she was no longer vulnerable and felt better.

The woman was supported by the Counselling Assessment Referral and Throughcare Service team (CARATs). (The CARATs team is a specialist service used in prison to support prisoners who have a history of substance misuse.) She went regularly to the substance misuse clinics and was referred to the mental health in reach team, although she did not always cooperate with them.

On 18 March 2010, the woman was taken to hospital as an emergency. Her heart rate was low, her breathing rapid and she was sweating. The following day she was discharged from hospital and returned to Styal without further medical interventions or treatments.

During the afternoon, the woman was assessed by a doctor as she had a fast heart rate and high blood pressure. The doctor told the woman she needed to return to the hospital. However, she refused to go and said she was scared of hospitals. After contact with the cardiology department, arrangements were made for her to return to hospital the following morning which she agreed to.

In the early hours of the next day, at 3.00am, the woman was transferred to hospital as her condition had deteriorated through the night. She was taken in a taxi as she was unhappy going by ambulance. Later that day she discharged herself against medical advice and returned to Styal at 11.30am. During that afternoon, her pulse rate was still low and her blood pressure was high. An on call doctor, in the prison to assess reception prisoners, declined to see the woman telling prison staff that she should be taken to hospital if her clinical observations were a cause for concern.

Despite the staff efforts to convince her, the woman refused to go back to hospital and night duty staff arranged to check her wellbeing during the night.

At about 3.00am, a nurse went into the woman's cell to take her clinical observations but she did not respond. Emergency medical staff and an ambulance were immediately called. The responding medical staff started CPR. The woman was taken to outside hospital and her death was confirmed at 4.40am.

I endorse the recommendation made by the clinical reviewer for the attention of the PCT and the Prison Health Partnership Board. I make a further recommendation about dealing with prisoners' families concerns when they contact the prison.

THE INVESTIGATION PROCESS

1. I appointed one of my senior investigators to conduct the investigation into this woman's death. He opened the investigation on 22 March 2010 by telephone when he contacted the Deputy Governor at Styal. My investigator outlined the terms of reference for the investigation and asked for the woman's prison file and medical records to be forwarded to him. My investigator had recently investigated another death at Styal and was familiar with the prison and its regime.
2. The Ombudsman's terms of reference and notices to staff and prisoners were sent to the Governor. My investigator's contact details were made available to members of the Independent Monitoring Board (IMB) and the Prison Officer's Association. (The IMB are volunteers who monitor the day to day life of the prison to ensure that proper standards of care and decency are maintained.) At the time of publication of the draft report, there has not been any response to these notices.
3. A review of the woman's healthcare was commissioned with Central and Eastern Cheshire Primary Care Trust. The review was undertaken by a clinical reviewer.
4. One of my family liaison officers contacted the woman's mother outlining the process of the investigation. On 30 April, my family liaison officer spoke to the woman's mother on the telephone and noted her questions and concerns about her daughter's care.
 - The use of restraints and her daughter's fear of hospitals.
 - A telephone call made by the woman to her mother the afternoon before she died concerned about taking anti-depressant medication with her heart condition. Her daughter asked her mother to contact the doctors so the prison could have access to her medical history.
 - Her daughter felt the prison did not have full information about her past medical history.
 - Her mother's effort to contact the healthcare unit at Styal on 20 March.
 - Breaking the news of her daughter's death to her mother.

I trust that I have addressed these concerns in the Issues section of this report.

5. My investigator visited Styal on 25 May and interviewed two doctors, a nurse and an operational support grade officer. On 15 July, my other investigator with conduct of this case visited Styal and interviewed two further officers and a nurse.
6. Solicitors acting on behalf of the woman's mother contacted one of my investigators on 20 July. The solicitor asked for certain medical issues

to be included in the clinical review. These issues were passed to the clinical reviewer who has addressed them in his review. In response to the draft report, in a letter of 19 November 2010, the solicitor acting on behalf of the woman's mother raised a number of additional issues. These are addressed at the end of the issues section of my report, paragraph 97.

In response to the draft report the National Offender Management Service (NOMS) makes reference to Annex 1, executive summary of the clinical review. They state that the woman arrived at Styal on 20 March 2009, and not on the 21 as stated in his report. NOMS also note that the clinical reviewer refers to the Keller Unit as a "specialist unit for prisoners with extreme psychiatric problems". They state that the Keller Unit provides enhanced levels of support to prisoners with complex needs.

HMP & YOI STYAL

7. Styal is the only local prison for women prisoners serving the North West of England and North Wales. It mainly accommodates women serving short sentences or those on remand. The prison has an operational capacity of 460. Waite wing has the capacity for 135 women in cellular accommodation.
8. Healthcare services at Styal are commissioned by the Central and Eastern Cheshire PCT. A doctor is based in the healthcare centre during weekdays and evenings. 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.
9. HM Chief Inspector of Prisons conducted a full announced inspection of Styal 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. In their annual report for 2007/2008, the IMB noted difficulties recruiting and retaining nursing staff. They related the high turnover in staff to the challenges entailed in dealing with a “demanding population” of prisoners. The IMB also noted that the healthcare budget was significantly under spent during the year 2007/2008, as it had been the previous year. They made the following comment:

“Bearing in mind the nature of the Styal’s 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.”
11. The woman’s death was the fourth death due to natural causes to have occurred at Styal since April 2004, when my office began investigating all deaths in prison custody in England and Wales. There are no similarities between the issues raised in this report and those addressed in previous investigations.

KEY FINDINGS

12. The woman was born in June 1967, and was the mother of two children who were looked after by other members of her family. She was unemployed and had recently lost her partner in a car accident. She used cocaine intravenously, misused alcohol and had a number of previous convictions, for which she had served several custodial sentences.
 - 12.1 In response to the draft report the woman's mother asked for the following paragraph to be added. "[The woman] loved her two sons and that although she had suffered drug addiction all her life, she was addressing the issues arising from her illness. She is missed terribly by her family and had many positive qualities including loving animals and being very creative."
13. On 29 April 2002, the woman was sentenced to 12 years imprisonment at a crown court for conspiracy to supply drugs. Following transfers to HMP Durham and HMP Buckley Hall, the woman was moved to HMP Askham Grange in York on 22 September 2005. Six months later, she absconded from custody.

March to October 2009

14. Three and a half years after she escaped, the woman was arrested in Blackpool on 20 March 2009. Following a court appearance, she was returned to custody at Styal. A first reception health screen document was completed by a nurse. The nurse wrote that the woman had a history of epilepsy, intravenous drug use, misuse of alcohol, a history of chest pain and had attempted suicide during her previous time in custody. She told the nurse that she had no thoughts of self harm, nor had she been in receipt of any medication for mental health problems in the community. It was further noted that she had been homeless. A high blood pressure reading of 143/108 was recorded (an average blood pressure is 130/80). She had a normal pulse rate of 72 beats per minute (bpm) (an average is 60 - 100 bpm).
15. The woman was assessed by one of the prison doctors. He recorded that she was dependent on alcohol and opiates, with recurrent drug-induced fits. (A urine test indicated that she had taken methadone and cocaine.) She was prescribed a stabilising programme of methadone, 40 millilitres (mls) and Librium. (These drugs are used to relieve drug withdrawal symptoms.) The following day, her blood pressure reading had fallen to within a normal range (137/74). It was further recorded that she had obsessive compulsive disorder (OCD) which was reflected in her fixation with cleaning and hygiene.
16. The healthcare centre made a request for the woman's previous medical records. However, it was noted that they had been lost within the prison system.

17. On 29 March, the self harm prevention measures Assessment, Care in Custody and Teamwork (ACCT) procedure were put in place by wing officers. The woman had told the officers that morning of her previous suicide attempt, which she said was due to issues with her medication while she was detoxifying. The woman said she was having similar concerns about her current medication and might attempt to hurt herself as a result. Additionally, she said her partner had recently been killed in a car accident and her father had cancer. For her own wellbeing, the woman was checked hourly during the day and twice each hour at night.
18. Regular ACCT case reviews to monitor the woman's progress were held over the next five months. The reviews noted that she progressed well. Her detoxification programme was supported through the substance misuse clinic, she had attended bereavement counselling and worked as a wing cleaner. The woman's ACCT document was closed on 12 August. She told the reviewing staff she had no intention of hurting herself and felt well.
19. The woman was referred to the Counselling Assessment Referral and Through Care Service team (CARATs) for support with her misuse. She was seen in the substance misuse clinic six times during this period. A member of the CARATs team referred the woman to the mental health in reach team, as he was concerned about her "low mood".
20. The notes of the woman's first attendance at the substance misuse clinic on 26 March indicate that she showed signs of withdrawal by shaking, sweating and aches and pains. She told the nurse that she had been using illicit drugs since coming to Styal. Three days later, she tested positive for cocaine, benzodiazepine (a tranquiliser) and methadone. Over the next few weeks, the dose of the woman's methadone was increased twice to 60mls. She was advised against using illicit drugs whilst taking the increased dose of methadone. Subsequent drug tests indicated that she was no longer using cocaine or benzodiazepines. CARATs case conferences were held to discuss her progression with her drug withdrawal symptoms and well being. It was agreed that she should be supported by both nursing staff, including the mental health in reach team and the CARATs team.
21. During one of the woman's substance misuse clinic appointments it was recorded that she had a poor appetite and insomnia. She was prescribed zopiclone to aid sleep and encouraged to eat and drink plenty of fluids. Support from the mental health in reach team continued. However, the woman did not always engage with them.
22. Despite some difficult times, mainly addressing her withdrawal symptoms and feelings of low mood, the woman settled on Waite wing.

She was noted to be a “willing and able worker” in the servery and as a wing cleaner.

October 2009 – February 2010

23. The woman was due to have a blood test to check her thyroid levels as she was experiencing mood swings, sweating and hair loss. She was concerned by this and told a nurse at a substance misuse review that she was worried about giving a blood sample. The nurse suggested relaxation techniques. The woman then attended the healthcare unit and the blood sample was taken.
24. In early November, another routine blood sample proved negative for any thyroid abnormality, however her potassium level was high. The doctor asked for an electrocardiogram (ECG) to be taken and a further blood sample. (An ECG measures the electrical activity of the heart to determine its rate and rhythms.) The ECG indicated that the woman had a slow heart rate.
25. A prison doctor spoke to the woman as she had become abusive to healthcare staff whilst they tried to take a second blood sample. The doctor explained the urgency of the second blood sample and the potential dangers to her health of a high potassium level in her blood. (High levels of potassium can indicate potential serious heart problems.)
26. The woman refused the blood test and admission to hospital despite encouragement from the doctor. The doctor also noted that the woman had full mental capacity to make this decision, and could not be forced to accept medical care against her will. She signed a disclaimer refusing medical treatment. The doctor made arrangements for close observations to be made on the woman and for staff to encourage her to re-consider her actions. Several weeks later, she consented to a blood test. The result indicated that she had no further health issues in relation to her potassium levels.
27. In January 2010, whilst attending a substance misuse clinic appointment, the woman told the nurse she still had a poor appetite and was not sleeping well. She would only eat food that had been wrapped as she was worried about food hygiene. Her concerns were attributed to her OCD.
28. A nurse met the doctor to discuss the woman’s symptoms. She had a history of eating disorders and OCD since her partner died and declined any help from the mental health in reach team. She was prescribed Ensure, a food supplement to help her maintain and improve her weight.

29. Following a further assessment, the woman was prescribed citalopram, an antidepressant, in February. Three weeks later she was noted to be brighter in mood and managing well on a 60ml dose of methadone.

18 March to the day of the woman's death

30. A nurse was called to see the woman in her cell on 18 March at 6.45pm. She told the nurse she had woken that morning feeling unwell and dizzy, and therefore she had rested throughout the day. An ECG was taken and analysed by telephone using Healthwatch. (Healthwatch is a telephone medical monitoring service which enables healthcare professionals to seek advice including the interpretation of ECGs.) In turn, Healthwatch advised the nurse that the woman should be taken to hospital as her heart rate was low. Whilst arrangements were being made to transfer the woman, she became sweaty, clammy and pale and started to breathe rapidly. She was given oxygen via a mask and an ambulance was called.
31. The woman was taken to outside hospital. She was escorted by two officers and was hand cuffed to one of these officers by the use of an escort chain. She underwent medical tests and returned to Styal later that evening. A nurse telephoned the hospital the following day, at 6.45am, as a discharge letter had not been sent back with the woman. The nurse was told by hospital staff that the woman had not had a heart attack and no further treatment was necessary. The hospital advised the nurse that the woman could see the prison doctor for any further treatment.
32. At 3.09pm, a locum doctor examined the woman and noted she had an episode of ventricular tachycardia (fast heart rate). She told the doctor that she was scared of hospitals. However, she agreed to be referred to a cardiologist. As a result of her high blood pressure (137/111) and an irregular heart rate, the locum doctor told the woman that she needed to go back to hospital. The doctor contacted the cardiology unit at outside hospital and arranged for the woman to be admitted. However, she refused to go, saying she would go the next day. The woman again signed a disclaimer refusing medical treatment.
33. At about 3.00am on 20 March, a nurse saw the woman in her cell. She told the nurse that she had pins and needles in her fingers with pain in her left arm. The nurse was unable to obtain a blood pressure reading. In view of her symptoms, the nurse decided that the woman needed to be admitted to hospital. The woman agreed and was transferred to hospital by taxi as she was unhappy going by ambulance. She was escorted by two officers and a restraint, in the form of handcuffs, was applied.

34. The woman was examined by a nurse in the accident and emergency department. It was written in the escort record that she was upset about being in handcuffs. The escort officers contacted the prison and it was agreed that the handcuffs could be removed and an escort chain was applied. (An escort chain is 1.8 metres long with a cuff at one end attached to an officer and a cuff at the other to the prisoner.)
35. At 7.15am, the woman was seen by a cardiologist who told her that she would be in hospital for at least 24 hours to undergo further tests. She was unhappy about this and told the doctor she would discharge herself at lunchtime. However, it was noted that she was “well-mannered” and “in good spirits”.
36. At 10.00am hospital staff told the woman she would return to Styal at some stage during the day, that her blood tests were normal and she may have suffered postural hypotension (a drop blood pressure caused by a change in body position). The plan was to use a five day heart monitor at a later date to monitor her condition. Hospital staff also told the woman she was suffering from bradycardia (a slow heart rate). At 11.30am, the woman returned to Styal after discharging herself from the hospital.
37. A nurse saw the woman at 12.17pm and noted that her blood pressure was 175/91 with a low pulse rate of 42bpm. She recorded that the woman had discharged herself from the hospital. The woman told the nurse that doctors at the hospital had advised her not to take her antidepressants and she therefore declined them at medication time. Two hours later, her blood pressure was taken again and read 171/95 with a pulse rate of 38 bpm.
38. At some stage during the day the woman wrote a note listing her symptoms and referring to the antidepressant medication she had been advised not to take. She did not address the note to anyone in particular. (It was found in the woman’s possessions following her death.)
39. The woman telephoned her mother before the evening meal. Her mother said afterwards that her daughter sounded concerned about her health however, she was able to have a positive conversation with her. The woman told her mother that she had been in hospital for an irregular heart beat and had discharged herself. She said the antidepressants had slowed her heart beat and she had told doctors that she had been seen by a heart specialist in Blackpool. The woman asked her mother to contact the hospital in Blackpool so they could send her notes through to the outside hospital she was currently attending. Her mother explained that she was doubtful that the hospital staff would speak to her. The woman then spoke to her mother about her fear of hospitals. However, although anxious, she would return to outside hospital the following Monday (22 March).

40. During the t