PRISONS AND PROBATION OMBUDSMAN for England and Wales

Independent Investigations

Investigation into the circumstances surrounding the death of a woman in April 2011 at hospital while in the custody of HMP Styal

Report by the Prisons and Probation Ombudsman for England and Wales

January 2013

This is the report of an investigation into the death of a woman who died in April 2011 at hospital aged 28. I offer my condolences to her family and all who have been affected by her sudden and unexpected death. A post mortem report gave the cause of death as acute subarachnoid haemorrhage and ruptured saccular cerebral artery aneurysm (brain haemorrhage).

The woman was found by a room mate unconscious on her bed on 26 April. An emergency ambulance was called and Styal's healthcare staff made efforts to revive her. She was taken to hospital and placed on life-support but did not regain consciousness. After consultation with her family, it was decided to discontinue life-support and she subsequently died.

The investigation was carried out by a senior investigator. Staff at Styal Prison cooperated fully with the investigation. The local Primary Care Trust (PCT) commissioned a clinical reviewer to carry out a clinical review of the healthcare the woman received at Styal. One of our Family Liaison Officers contacted the woman's family to explain the Ombudsman's role and to learn of the particular concerns they had about her death. I apologise for the delay in producing this report, however I hope it has helped her family to have a clearer understanding of the events leading up to her death. After having the opportunity to consider a draft version of this report, the woman's mother commented "What hurts the most in reading the report is that this condition was treatable and if she had got the care she needed, she would still be here".

The clinical reviewer raised significant questions about shortcomings in the woman's treatment. Although he made no recommendations, we consider that her severe symptoms were not further explored and, therefore, the opportunity for an intervention that might have saved her life was lost. Accordingly, the report recommends that Styal takes formal steps to learn from this tragic case about the importance of careful analysis of symptoms associated with headaches.

The investigation also raised some troubling concerns about the professionalism and compassion of some healthcare staff, and makes a recommendation regarding their recruitment and training. Recommendations also address the need for reduced waiting times to see a doctor, effective support for staff and prisoners after a traumatic event, improved procedures for effective healthcare assistance when an officer raises concerns about a prisoner, better recording on clinical records and the avoidance of delays when calling an ambulance.

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.

Nigel Newcomen CBE
Prisons and Probation Ombudsman **January 2013**

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SUMMARY

1. The woman was sentenced to a total of 18 months imprisonment on 30 March 2011. She returned to HMP Styal from court that day, and while she was being escorted back to her residential unit, Waite wing, she collapsed suddenly. A radio request for emergency healthcare assistance was made and she told the nurse who attended to her that she had a headache at the back of her head (known as an occipital headache) before falling. The nurse discussed her symptoms with the duty doctor by telephone, who asked for neurological observations to be made hourly. Over the course of the evening, her headache seemed to improve so the observations were reduced to once overnight and she was given paracetamol.

2. On 1 April, the woman complained of a headache twice during the day and again on 2, 5 and 7 April. She woke up complaining of head pain on 9 April. A nurse examined her and although her blood pressure was within the normal range as were her body temperature and pulse rate, she scheduled her for an urgent doctor's appointment that day but it did not take place. The prison has been unable to explain why this did not happen.

3. The woman was seen by a locum General Practitioner on 11 April. She recorded in her clinical notes that the woman had collapsed two weeks previously and had since complained of waking up with a left-sided headache. She had nausea when the headaches were severe, her vision was normal, the back of her eyes ached and the left side of her face felt numb but paracetamol took the edge off the pain. The doctor recorded her diagnosis as "?migraine?other pathology". She prescribed rizatriptan (pain killer) for migraine and noted her plan that an optician should examine the interior of the woman's eye and her case should be reviewed once the eye examination had taken place.

4. She moved from Waite wing to Davies House on 13 April. A prisoner, who also lived in Davies House, told the investigator.that she had seen the woman holding her head and crying on more than one occasion because of the pain she was experiencing. She said the woman was scared and thought she was being "fobbed off" by healthcare staff.

5. At about 9.00am on 26 April, as the woman was about to leave Davies House to attend education classes, she suddenly started crying and said she had such a severe headache that she could not go out. An officer who was on duty urged her to lie down while she contacted the healthcare centre by telephone. The officer said that she had tried four times over 20 minutes but the telephone rang without being answered. As the woman was visibly unwell and had vomited, the officer decided to go to the healthcare centre in person to ask for her to be seen by a doctor.

6. The officer asked the two nurses she saw in the pharmacy whether the woman could see a doctor as she was really unwell. The nurses told her the list was full and she could not be squeezed in. Neither asked who the ill prisoner was and what was wrong with her, or assessed the urgency of the situation.

7. When the officer returned at just before 11.00am, a prisoner told her that the woman had fainted in the bathroom. The officer immediately radioed for urgent medical assistance. She was examined by two nurses. One nurse wrote in the woman's clinical record that she was reporting headaches that were increasingly worse than those she had been experiencing previously and she had requested to go to hospital. She had told the second nurse that she had fallen in the shower and had been unable to get up. The nurses carried out clinical observations and then the second nurse telephoned Styal's General Practitioner, who was in the healthcare centre, for advice. He wrote in her clinical record that her observations were within the normal range and prescribed sumatriptan (pain killer) to ease her headache given her history of "known migraine."

8. The GP examined her half an hour after she had taken the sumatriptan. He did not have access to her electronic clinical record as the consulting room was being used by the triage clinic so took a verbal clinical history from her. He concluded that if she had not improved significantly by the afternoon, he would see her again after his clinic finished at 4.00pm.

9. When the woman returned to Davies House, the officer advised her to rest upstairs in her bed. At about 3.25pm, a prisoner was woken by her making a gurgling sound. As she was unable to rouse her, she ran downstairs to raise the alarm with an officer who had taken over duty from the previous officer. The officer radioed for urgent medical assistance and tried to wake her, but she did not respond. The officer repeated her radio message and healthcare staff, arrived and tried to resuscitate her.

10. The officer radioed for an ambulance at 3.37pm after the woman went into cardiac arrest but one did not arrive until 3.59pm. Paramedics tried to stabilise her condition and she was taken to hospital at 4.40pm. On arrival, she underwent a scan which showed that she had suffered a brain haemorrhage. She was placed on a life-support machine. Her family was told and they made their way to the hospital.

11. After further testing in the Intensive Care Unit, her family were told she was unlikely to regain consciousness. With the agreement of her family, the life-support machine was turned off and she died with her family at her bedside. A post mortem examination report gave her causes of death as acute subarachnoid haemorrhage and ruptured saccular cerebral artery aneurysm (brain haemorrhage).

12. A clinical review of the woman's medical care was carried out by a clinical reviewer of the local Primary Care Trust. He considered that staff had placed undue reliance on the "plausible but erroneous diagnosis of migraine". His report concluded that she had a treatable condition and if the symptoms she had described were examined more critically, it could have led to a different course of action being pursued. He does not make any recommendations. We make eight recommendations about the management of head pain, the recruitment and training of staff, procedures for securing effective assistance when an officer raises concerns about a prisoner, the support for prisoners and staff after a traumatic event and avoidance of delay when calling an ambulance.

THE INVESTIGATION PROCESS

13. The Ombudsman's office was informed of the woman's death in April 2011. The investigator visited HMP Styal and was given access to her prison records covering her stay at Styal, including her clinical record, statements from staff and other documentation.

14. Notices to staff and prisoners announcing the investigation and inviting anyone with any information to come forward, were displayed. No written responses were received. The investigator met representatives from the Independent Monitoring Board (IMB) (independent and unpaid members of the community who are appointed to each prison to ensure that prisoners are being cared for humanely) and the local branch of the Prison Officers Association to offer them the opportunity to raise relevant issues. The IMB were concerned about the lack of support for the residents of Davies House in the days after the woman's death.

15. One of our Family Liaison Officers contacted the woman's mother to explain the investigation process and to give her the opportunity to raise any concerns or issues. She was concerned whether her daughter received appropriate medical assessment and intervention in the light of her headaches and felt that she should have been taken to a hospital for treatment. She said that her daughter had written to her from Styal a few days before her death and said in the letter that it had taken her two weeks to see a doctor after she had collapsed and described experiencing "very bad headaches". She commented that her daughter must have been in considerable pain at that time as she was not a person who would normally mention feeling unwell. After reading a draft version of this report, she said "The care simply was not there for her. She … must have been suffering to have spoken of the pain at all. They ignored her requests for help and ignored the signs she was displaying – a migraine simply would not last for 2 weeks".

16. The investigator visited Styal three times and conducted interviews with a number of staff and prisoners who knew or had contact with the woman. Some interviews with staff were delayed due to sick absences, night duties and annual leave. This led to delays in obtaining information which, contributed to the delay in this report being produced.

17. The local Primary Care Trust appointed a clinical reviewer to undertake a review of the clinical care the woman received at Styal. He received copies of relevant medical documentation on which he based his findings. This included examining her clinical record, undertaking a review of the appropriate literature and discussion with Styal's main General Practitioner (GP).

18. The investigator contacted HM Coroner for Cheshire to inform him of the nature and scope of the investigation and to request a copy of the post mortem. A post mortem examination conducted by a Home Office pathologist gave the woman's cause of death as acute subarachnoid haemorrhage and ruptured saccular cerebral artery aneurysm.

HMP STYAL

19. HMP Styal is a closed prison in Wilmslow, Cheshire for up to 459 unsentenced remanded women and women serving a full range of sentences up to and including life imprisonment. There is a variety of residential units depending in part on the needs of individual women prisoners, risk and the degree of staff supervision needed. There are 13 detached Victorian houses, each with their own dining room and communal area which have up to 16 residents in shared rooms. There are periods when some houses are not staffed. In addition Waite wing, a large purpose built unit, holds up to 134 women mostly in single cells. Women who require closer healthcare support, are vulnerable, experiencing drug withdrawal or pose a risk to others are likely to be accommodated in Waite wing. There is a small unit, Keller, for women with serious mental health or behavioural issues who need intensive support and supervision. The prison also has a mother and baby unit

20. Up to16 women live on Davies House, where the woman lived from 13- 26 April. There are six twin rooms, one four-bedded dormitory and bathrooms upstairs. The communal areas, dining room, food servery, and staff offices are on the ground floor.

Healthcare at Styal

21. Healthcare at Styal at the time of the woman's death was provided by the National Health Service and is commissioned by the local Primary Care Trust. Residents in Davies House collect their medication from the healthcare centre which is about one minute's walk away. A General Practitioner is based in the healthcare centre during weekdays. An on-call service provides cover overnight and Sundays. On Saturday afternoons, a locum doctor visits primarily to check the health of newly received prisoners but who will examine any other prisoner who is unwell.

HM Inspectorate of Prisons (HMIP)

22. HMIP carried out a full inspection of Styal in September 2008 and a follow up inspection in July 2011. In the 2008 inspection the Chief Inspector commented that health services were under constant pressure with exceptional levels of health needs.

23. The 2011 inspection report confirms there are still issues:

> "In our survey, women appeared fairly equally divided as to whether the quality of health care was good or poor and we found a mixed picture. Women either asked for a GP appointment or put in an application using the confidential boxes that were emptied by health care. Daily GP clinics were held in main health care and on Waite wing. There were waits of two to three weeks for some routine appointments, which was too long. Urgent referrals could be seen the same day. In our groups, some women voiced concerns about long waits to see the GP and this was borne out by the time taken between referral to the GP and the actual appointment. Access to out-of-hours medical care was through the local PCT GP service. There

had been two instances in recent months where the response time by the ambulance had been too long.”

Independent Monitoring Board (IMB)

24. In their last published annual report covering the period May 2009 to April 2010, Styal’s IMB highlighted that approximately 80% of its population had serious drug problems and almost 40% were in custody for the first time. The Board noted that the use of agency nurses had reduced significantly but access to GP appointments was a concern. Overall the Board described the staff at Styal as a highly motivated team of professionals.

25. Since the Ombudsman began investigating deaths in custody in 2004, there have been five deaths from natural causes at Styal, including the woman. One of these was also due to a brain haemorrhage, however apart from the cause of death there are no similarities in relation to care or diagnosis.

KEY EVENTS

26. The woman was remanded in custody on 21 February 2011 after appearing at Magistrates Court. She was taken to HMP Styal. It was her first time in prison. Her contact with healthcare staff at Styal was recorded in her clinical record.

27. She told the nurse who interviewed her as part of the normal healthcare reception process for newly-arrived prisoners (this interview highlights any immediate mental or physical health problems requiring referral to the doctor or other specialist service) that she had a history of misusing illicit drugs such as crack cocaine and heroin and had also misused amphetamines (a stimulant, sometime known as 'speed'), solvents and benzodiazepine (a group of sedative drugs that include diazepam) tablets. She agreed to begin an opiate stabilisation programme. This is designed to relieve the symptoms associated with drug withdrawal by taking daily doses of methadone (a heroin substitute) in a supportive environment and to start diazepam detoxification treatment.

28. The woman spent her first two days in Styal's First Night Centre, which is a residential unit dedicated to meeting the needs of prisoners new to Styal and providing an induction on how the prison is run. The induction manual says of Healthcare "IN AN EMERGENCY, you can report to your Landing Officer, who will contact the Health Care Centre for assistance ". The words "Secreting diazepam 26.2.11" were written on the front page of her prescription chart but the comment is not initialled nor is there any reference in her records to any further information or action.

29. A staff nurse conducted a review of the woman's substance misuse history on 28 February. She told her that after losing her job, she also lost her living accommodation and found it difficult to manage financially without stealing, as she was still dependent on drugs. She viewed prison as an opportunity "to sort herself out". As she was suffering withdrawal symptoms, her prescribed methadone was increased from 30mg daily to 40 mgs. She continued on the methadone maintenance programme for the rest of her time at Styal.

30. She appeared at Crown Court on 9 March where she entered a guilty plea and was remanded in custody until 30 March for a pre-sentence report prepared by a probation officer outlining the background to her offending.

31. On 6 March, Styal's security department received information that the woman was scared of the woman with whom she was sharing a cell on Waite wing as there had been problems in the community between them before they were in prison. She told a member of staff that the woman was using heroin in their cell and the other woman said the woman was doing the same. She made a written formal complaint about her cell-mate. The governor in charge of Waite wing told the investigator that he spoke to her in person and she was satisfied the matter had already been dealt with appropriately. The Education Manager and the woman's tutor explained that she was moved to another cell after she complained to the Education Manager that she was being bullied. The Manager had discussed the matter with a Senior Officer (SO) of Waite wing

and the Tackling Anti-Social Behaviour strategy (TAB) was used to monitor the situation and support her as a victim.

32. The tutor told the investigator that the woman had mentioned having a headache a few times but did not seem to be in a great deal of pain. On one occasion, she said the woman had mentioned her father dying of a brain aneurysm and said "I hope I don't know" but did not elaborate. This did not appear to be accurate - after her death her mother told police that a relative by marriage had died of a brain haemorrhage not any blood relative.

33. On 30 March, the woman was sentenced to a total of 18 months imprisonment. On her return to Styal from court, she was assessed by a nurse as a newly-sentenced prisoner. She told the nurse she was happy with the sentence she had been given and wanted to start on a drug detoxification programme. The nurse updated her electronic clinical record at 4.40pm.

34. As the woman was being escorted back to Waite wing from reception, she collapsed at the gates of the wing and fell to the floor. A radio request for emergency attendance by healthcare staff was made (known as a Code Blue which indicates that the prisoner has breathing difficulties). A nurse, who was carrying the healthcare emergency response radio, was on Waite wing and responded to the call. She told the investigator that she asked the officer who was with the woman what had occurred but the officer "was unclear as to what had happened, whether she'd tripped and fallen or whether she'd collapsed, fainted …" The nurse found that she had no history of losing consciousness, no neck pain and no head injury. The woman said she had a headache at the back of her head (known as an occipital headache) before falling. The nurse discussed her symptoms with the duty doctor by telephone. The doctor asked for neurological observations to be done hourly. Over the course of the evening she seemed to improve so the observations were reduced to once overnight.

35. A nurse checked on the woman at 9.41pm on 30 March. She said she had vomited but showed no other signs of discomfort. At midnight, the nurse gave her paracetamol for a headache. She was reviewed at 5.42am the next morning by the nurse, who wrote in the clinical record that she appeared to have slept well and had not made further complaints.

36. According to the woman's Prescription and Administration Record Chart, she complained of a headache again on 1 April and was given paracetamol at 8.40am and again during the day. The column on the prescription chart entitled "special sick" records when patients are given over-the-counter medication. This shows that she reported having a headache and asked for medication on 30 March, twice on 1 April, 2 April, 5 April, twice on 7 April and for the last time on 26 April.

37. On 5 April, after complaining of a persistent occipital headache, the woman saw a nurse at the triage clinic in the healthcare centre. Triage is a means of assessing health conditions so that urgent and/or acute conditions are given priority over less pressing concerns. The nurse noted that her blood pressure reading was normal, she did not have a pallor (was not pale), visual disturbance or vomiting. The nurse told the investigator that she was not

unduly concerned as she had carried out a basic neurological assessment. However, because the woman was still complaining of a headache she advised her to make an appointment to see a doctor. According to Styal's General Practitioner, who after the woman's death compiled a report into her care, "a planned medical review was booked that day for the 11 April 2011, which was the next available routine appointment".

38. The woman woke up complaining of a head pain on 9 April and was examined again by a nurse at 8.03am. As this was relatively early in the day, the nurse thought she might have been asked by an officer to see her in her cell. She noted that on the Glasgow Coma Scale which measures levels of consciousness (3 being deep unconsciousness to 15 being alert) she scored 15, she was not pale, clammy, vomiting or unwell. She denied using illicit drugs, and was willing to provide a urine sample for drug screening. Her blood pressure was within the normal range (140/90) as were her body temperature and pulse rate. The nurse wrote in the clinical record "Plan: for urgent MO appointment today." However, she was not seen by a GP until two days later. Asked at interview whether 9 April being a Saturday might have had a bearing on the availability of a doctor, the nurse explained that a locum doctor was available on Saturdays and would see any patient that healthcare staff were concerned about. She could not explain why that did not happen in this case.

39. A locum GP saw the woman on 11 April. She recorded that the woman had collapsed two weeks previously and since had complained of waking up with a left-sided headache. The woman was reported as saying that she had nausea when the headaches were severe, her vision was normal but the back of her eyes ached. Also that the left side of her face felt numb but paracetamol took the edge off the pain. She mentioned an aunt who had died of a brain haemorrhage.

40. The locum GP recorded her diagnosis as "? migraine ?other pathology" and noted her plan that an optician should review the woman's fundus (eye interior). She also noted "trial of ibuprofen for pain, rizatriptan for migraines, review post optician." She prescribed 14 days of rizatriptan 10mg wafer (for the treatment of migraine) to be taken at the onset of a headache.

41. The woman continued to take her methadone but expressed her wish to undergo detoxification during an Integrated Drug Treatment System (IDTS) review on 18 April. (IDTS is a programme in prisons to increase the quality and range of substance misuse treatments available in prisons. It focuses on prisoners as individuals and aims to break the link between drug use and offending behaviour). She was unhappy that Styal's drug treatment specialists did not support her wish at that stage because of her history. She said she would start reducing her dose of methadone if she was not supported. She was warned about the risks of doing so when her situation was not stable.

42. Prisoner A was friendly with the woman at Styal. She told the investigator that she knew her slightly from seeing her around her home area. She spoke to her about the headaches she was having and said her head was pounding as

if it would explode: “She was always going on about her head. She had been talking about her head for a good few weeks before”.

43. Prisoner B told the investigator that she saw the woman holding her head and crying because of the pain. She described it to her as extreme pain which would last for an hour or so although the migraine medication eased it. The prisoner said conversation with her at those times would be impossible. She told the police that she told her she collapsed twice on Waite wing. She complained of headaches daily and was taking migraine medication. The prisoner told the investigator:

> “I knew that she was scared about the headaches and thought she had something seriously wrong with her. She thought that she was being fobbed off by medical staff.”

44. Prisoner C, who lived on Davies House, said the woman complained about headaches from the time she moved to Davies House from Waite wing on 13 April. She described an incident she said occurred about a fortnight before she died. The prisoner said that on their way back from collecting medication in the Healthcare Centre, the woman said to her “Look what the nurse wrote” and showed her a piece of paper which was an article about medical negligence in prisons cut out of the prisoners newspaper ‘Inside Time’. The woman said she had shown it to one of the nurses dispensing medication. The nurse read it then drew a speech bubble and wrote the words ‘so sue me’ in it. The investigator was unable to corroborate this account.

45. On 20 April, the woman had a dental appointment with a nurse to examine a broken crown and wisdom tooth. At interview, the nurse said she told her she was having severe headaches which were causing her discomfort but they were being investigated. The nurse took her medical history and noted what medication she was taking. She asked whether lights or having dental treatment could trigger the headaches. She replied that it was possible using a drill might and that she had really bad migraines”. The nurse made an appointment for her to return on 5 May for an x-ray.

46. On the same day, after her dental appointment, the woman wrote a letter to her mother. She spoke about how much she liked living in Davies House as opposed to Waite wing, her enjoyment of her education classes and her determination to live a more positive life in the future (“I’m not going back down that road … I will put all my wrongs right.”). Concerning her health she wrote:

> “Things have been alright here. I was really ill the other week. I collapsed after I got back from court on the 30th, had a code blue! But it took two weeks to see the doctor. I’m ok, got really bad headaches, still got them, the doctor said there’s something at the back of my right eye that isn’t at the back of my left, got an appointment with the optician on the 28th April so my headaches should go. Well hopefully.”

47. An officer was on duty on Davies House the weekend just before 26 April. At interview, she recalled that the woman had complained to the other residents

of a headache in the back of her head all weekend, saying that she could not get rid of it and it was annoying her. The officer said in her police statement:

> "She did look in some discomfort and was holding her head, however, she did laugh on one occasion when she was wearing glasses that she had borrowed saying they eased the pain. I did tell her to speak to the nurse about the headaches but have no way of confirming whether she had."

The morning of 26 April

48. On 26 April, an officer started work at 7.30am and was on duty on Davies House. At about 8.00am, she checked that all the residents were present and awake. The woman shared a dormitory with three other young women. There were two sets of bunk beds. She slept on the top bunk of the beds facing the door. In her police statement, one room mate said she and the woman had got up, dressed and she smoked a cigarette as they sat in their dormitory. At about 8.30am, she got up to put her cigarette out and as she did so she banged the back of her head on her bunk. The inmate did not think it was a hard bang and the woman laughed about it.

49. Between 8.45am and 9.00am, Davies House residents began to gather in a queue in the hallway downstairs so that the officer could unlock the door to let them out and cross them off her check list when they were going to their work place or education. Just before 9.00am, the woman went downstairs carrying her education class folders. The officer described her sudden distress:

> "As she got to the door, she seemed to break down. She started crying and said that her headache was so severe that she couldn't go out. This time she looked in pain, her face was all screwed up and she was holding her head."

50. The officer urged her to go and lie down on a sofa in the television room until the other women who were leaving the house had gone. One of her room mates said she saw her crying and holding her head. She said the pain was at the back of her head and tried on another prisoner's glasses to try to ease it. The officer told her she would contact healthcare and ask for a doctor's appointment. The officer said she telephoned the nurses station at the healthcare centre four times over 20 minutes but it rang without being answered. She thought that the nurses might be dispensing medication at the other end of the healthcare centre but had hoped someone might pick it up. She went back to the television room to check on her and thought she looked poorly.

51. The woman then went upstairs to bed. She took a paracetamol with water and asked one of her room mates to wake her up when it was time to collect her methadone (at around 10.00am). The room mate went downstairs to give her a chance to rest. On entering the television room, she saw vomit on the floor and on the coffee table. With the help of another prisoner they wiped it up and told the officer that the woman had also been sick in the toilet. The officer spoke to her and explained that she would not be letting her collect her methadone until she was feeling better. (This is because when someone has vomited, it is difficult for nursing staff to gauge how much methadone has

been ingested which can lead to potentially serious consequences if the dose is miscalculated.)

52. As the woman was visibly unwell and the officer was unable to contact a healthcare worker, she decided to go to the healthcare centre herself. She told the investigator that she had only done this three times in the 17 years she had been a prison officer, but she could see the agony in her face and wanted her to see a doctor before she finished her shift at lunchtime.

53. The officer said she went into the healthcare centre just before 10.00am intending to speak to the triage nurse with a view to getting the woman a doctor's appointment. She saw two nurses in the Pharmacy, one of whom she recognised. At interview she said :

> "I nipped in and there were two nurses and I said 'Is there any chance you could get one of my girls who's really poorly in to see the doctor? One nurse said 'No, it's full' but then she turned around … [to] the other and she said 'well you're the triage nurse, what do you think?' So she [the other nurse] said 'No, we are actually really full.' I did say, like, 'Can you not squeeze her in?' she went "Not really."

54. The nurses did not ask who the ill prisoner was or what the problem was to determine whether it was urgent. The officer returned to Davies House to carry out the rest of her duties and did not mention what had happened in the healthcare centre to anyone else that morning. She had to leave again almost immediately to carry out another task. On her way back to Davies House, she got a radio message to say that Prisoner B had pressed the call bell because the woman was unwell.

55. The investigator established who the triage nurse was that the officer spoke to. When asked at interview whether she could remember any member of staff asking her in the healthcare centre that morning if a prisoner could be seen, she said she did not recall an officer doing so. Asked what she would do if an officer told her about a prisoner who was unwell, she said in the past when she worked on Waite wing, she had gone to see such prisoners and advised them to make an appointment or she would make an appointment for them if it was more serious. The nurse said that on the day the woman had taken ill, it was her first day on duty in the Healthcare centre. Not only had she issued medication, methadone and conducted a triage clinic, she was also required to be the first radio response healthcare member of staff for medical emergencies (a practice which HM Inspectorate of Prisons had previously criticised).

56. Similarly, when interviewed, the other nurse could not recall the officer coming into healthcare or asking for a doctor to see the woman. When asked what she would normally do should this situation occur, she replied that a doctor would be approached.

57. When the officer returned to the house, Prisoner B told her that the woman had passed out in the bathroom. At 10.55am, the officer radioed a Code Blue to ask for urgent medical assistance. She went upstairs and saw her lying on her bed in the top bunk. She looked in pain but was conscious and breathing.

Two nurses arrived to attend to her and moved her to the bottom bunk. According to the officer, one of them was the triage nurse she had seen earlier in the healthcare centre and the other was Nurse A. Nurse A wrote in the clinical record:

> "Patient aware of surroundings, reports headaches increasingly worse than weekend, requesting to go to hospital. Denies taking fluids on regular basis – patient encouraged to do so. Expressed that she has vomited – no vomiting whilst present, no injuries sustained from reported faint. Informed patient shall discuss with MO once available to potentially review patient due to apparent waiting for outside appointment."

58. According to the clinical record, the woman told Nurse B that she had fallen in the shower and had been unable to get up. She described how unwell she was feeling with a pain at the back of her head and said it hurt when they shone a light into her eyes. The nurses carried out clinical observations then Nurse B telephoned Styal's General Practitioner, who was in the healthcare centre for advice. He wrote in his report of the healthcare she received. Nurse B reported,

> "She seemed to be in pain with a migraine. A full set of observations was taken and recorded as within the normal range. From the history given (known migraine) an immediate dose of Sumatriptan was advised (to prevent vascular changes in the brain associated with migraine headache) with a planned review."

59. Nurse B and a Healthcare Assistant (HCA) returned to Davies House with the medication for her.

60. After taking the sumatriptan, the woman walked to the healthcare centre to see the GP, accompanied by her room mate. The doctor did not have access to her electronic clinical record as the consulting room was being used by the triage clinic so he took a verbal clinical history from her. He deduced from what she said that she was experiencing a chronic headache which was getting better with migraine treatments. She sometimes experienced nausea, pins and needles and visual disturbance. He wrote that her history was not consistent with 'thunder clap onset' which reflects causes of headache that may indicate bleeding from the brain (cerebral haemorrhage). He tried to examine the back of her eyes but was unable to as she could not tolerate light being shone into her eyes. The clinical record states,

> "Given the reported history of migraine, the symptoms she offered during the consultation with the doctor and on the basis of elicited signs, an ongoing prescription for sumatriptan … ibuprofen (an analgesic) and pizotifen (a treatment for the prophylactic treatment of migraine) were commenced."

61. If the woman's symptoms had not significantly improved by the afternoon, the doctor planned to see her after finishing his afternoon clinic which was scheduled to take place between 2.00pm and 4.00pm.

62. The woman returned to Davies House just after 12.00, midday. She told the officer she had seen the doctor and was fine. She said she was not hungry. The officer said that she was calm and not distressed, but in view of how drained and worn she looked she told her to go upstairs to bed for a rest and she would check on her. A short time later one of the residents told her she was asleep. Towards the end of her shift which finished at 1.30pm, she gave a verbal handover of duty to another officer, summarising her concerns about the woman's health and asking the officer to keep an eye on her.

The afternoon of 26 April

63. The officer who took over recalled that the previous officer spoke to her about each prisoner who would be on Davies House that afternoon. She was told that the woman had been unwell that morning and for a couple of days previously. She was suffering head pain, had been seen by healthcare staff and was resting in bed. At 1.30pm, the officer supervised the women leaving Davies House for work or education and let the cleaners in. As she did not work there regularly she then went upstairs to check which prisoners were still in the house. She saw the woman lying on her bed in dormitory 3 and told her the previous officer had mentioned she would probably be staying in bed. She replied "Yes Miss". The officer then left the house for 30-45 minutes to complete errands. One of the room mates had moved into another room and Prisoner A, who had known her from her home area, took her place. The prisoner placed her belongings on the other top bunk and asked her how she was. She described her as looking "grey and poorly". She said she had a severe headache and when the prisoner opened a window to smoke a cigarette, she asked her to close it because she was cold. She said she spent a few minutes in the room and asked her whether she should stay away from work to look after her. She replied "No". The prisoner described her voice as husky, as if she was trying to catch her breath. .

64. Prisoner B went into to the dormitory at about 1.50pm. She noticed that the woman was lying on her back asleep and appeared fine, she lay on her own bed and fell asleep too.

65. At 2.34pm, a Code Blue emergency radio message was made by a member of staff working in the visits areas after a baby was reported as unwell. An ambulance was requested at 2.36pm and cancelled at 2.39pm after the child was examined by the GP. At 3.02pm, the ambulance was requested again and despatched at 3.04pm. It arrived at 3.22pm and left at 3.34pm, the situation having been resolved. (This incident is relevant to the timing of the ambulance called later for the woman.)

66. Prisoner B told police that as she was waking up at about 3.25pm, she heard a noise that she took to be the woman snoring. She was known to be a heavy snorer. However, as she became more awake, she realised that she was in fact making a "gurgling" sound. She got out of bed immediately and went over to her bunk. She was lying on her back foaming from her nose and mouth. After spending about five seconds trying to rouse her to no avail, she ran downstairs to find the officer, who was in the staff office, telling her that the woman had been sick and was not answering her.

67. The officer went upstairs with the prisoner and saw the woman lying on her back, gurgling, with mucus running down one side of her face from her mouth and nose. She radioed the communications room with a Code Blue for urgent medical assistance and asked the prisoner, who was quite distressed, to wait by the front door downstairs and direct healthcare staff to the correct dormitory. The communications room logged the timing of the Code Blue as 3.27pm.

68. The officer stood on a chair to reach the woman (who was on the top bunk) shook her and called her name but there was no response. She tried to push her on to her side to ease her breathing and noticed that her heart was thumping strongly against her ribcage and her pulse was racing. The officer radioed again that medical assistance was needed urgently. The communications room responded that assistance was on its way. The officer told the investigator that she was not first-aid trained but she held the woman on her side in an effort to assist her breathing.

69. Another officer who was working nearby in Martin House heard the officer's second Code Blue radio message that she needed an urgent response and arrived at Davies House to assist her at about 3.28pm. He stood on a chair and helped keep the woman on her side facing the window until a nurse arrived a minute later followed by a Health Care Assistant (HCA). The prisoner told the police that the first two nurses walked to Davies House although she beckoned them to come quickly. One of them said to her as they entered the house "we can't run because then we would be out of breath" which she thought was an unusual comment. Prisoner C said that she was on Davies House when the woman had been found unconscious. She went into her bedroom which was upstairs at the front of the house and looked out of the windows which overlook the path and saw two nurses "strolling" towards the house. She said she shouted down to them "Do you want to hurry up?" and one of them replied "We don't run, it's only a headache". She could not recall who the nurse was.

70. The nurse asked for the woman to be placed on her other side facing the door. She asked the HCA to get a suction kit and then asked the officer for something to wipe the woman's face. The nurse asked the officer to radio for the doctor to attend urgently. The officer asked over the radio for the doctor at 3.31pm. Two more nurses arrived, one of whom checked the woman's eyes. At this point, she stopped gurgling and the nurse said she had gone into cardiac arrest.

71. At 3.37pm, the officer radioed for the communications room to call an ambulance, and followed this up with a telephone call to provide the communications room with information on the woman and her condition. The doctor and the Head of Healthcare arrived on Davies House and asked for the woman to be placed on the floor (it is best practice to perform Cardio Pulmonary Resuscitation (CPR) on a hard surface) CPR is a combination of rescue breaths and chest compressions, carried out to ensure oxygen and blood continue to circulate around the body. The doctor asked a nurse to begin chest compressions in an effort to resuscitate her. Other healthcare staff took it in turns to assist with chest compressions. An automatic electronic defibrillator (a machine which analyses heart rhythm and indicates

whether an electric shock should be administered) was attached to her chest. During attempts to resuscitate her, the defibrillator did not advise that a shock should be given.

72. According to the prison records, the ambulance arrived at Styal at 3.59pm, some 22 minutes after it was called. The paramedics tried to stabilise the woman's condition and her heart was beating but her blood pressure and oxygen levels were falling. Her pupils were fixed and dilated. When her condition had been stabilised by paramedics, she was taken to hospital by ambulance, which left Styal at 4.40pm accompanied by two officers and a nurse. A Communications Assistant and duty governor prepared an escort risk assessment on the level of risk she posed to the public. It was agreed by the Head of Safer Custody that she should not be handcuffed. The nurse was advised by the doctor to tell Accident and Emergency staff at the hospital that a CT scan (computerised tomography scan – which uses x rays and a computer to create detailed images of the inside of the body) would be required urgently. On arrival at the hospital, she was taken to the Accident and Emergency department. She underwent a CT scan which showed that she had suffered a brain haemorrhage.

73. Styal's Family Liaison Officer, a governor, contacted the woman's mother to inform her that her daughter had been taken to hospital. She and the Deputy Governor met the mother and uncle at the hospital and explained their roles.

74. At 4.52pm, a hot debrief (an immediate meeting for staff involved in caring for the woman once the alarm had been raised and handling the aftermath) took place. It was led by the Head of Safer Custody and gave staff the opportunity to discuss how the situation had been managed. All staff were reminded that the Staff Care Team was there for support should they need it.

75. While healthcare staff were working to revive the woman, the residents who were already on Davies House were asked to remain in the television room until she was taken to hospital. After seeing the care team on the insistence of a Principal Officer (who was co-ordinating the incident management between the staff on the ground and the duty governor), the officer went back to Davies House once the ambulance had left and carried on with her shift. She told our investigator that it was her choice to remain on duty and she felt she had received sufficient support. She went into the television room to speak to the women and found them distressed and upset. She said she tried to reassure them that staff would let them know what was happening when more information was available. Prisoner B was angry and said that not enough had been done for the woman, given that she had complained for days about headaches. She felt that the woman should have been taken to hospital earlier. Other residents echoed that she had been unwell for a few days. The officer spoke to Prisoner B in private and asked her whether she wanted to speak to a Listener or a particular friend. (Listeners are selected prisoners trained by the Samaritans to listen to and support other prisoners who are experiencing distress or are at risk of harming themselves. This is a confidential service).

76. The prisoner asked instead whether she could telephone her mother and the officer allowed her to do so from the staff office. The prisoner told the

investigator that some time later a senior officer had asked her whether she wanted bereavement counselling but this was never followed up. She added that certain officers who worked on Davies House regularly had been very supportive. As their dormitory had been sealed off to prevent unauthorised access, the woman's room mates were taken to another residential unit, Willow House, that evening and given nightclothes and toiletries. The next day they were given clothes as their personal belongings had remained in the dormitory when it was sealed.

77. Nurse B told the investigator that after she had participated in the efforts to resuscitate the woman by doing chest compressions, monitoring her pulse, keeping her airway ventilated and assisting the paramedics, she was not seen by the care team at the time. She said she took a cigarette break outside the prison and the Head of Healthcare asked her how she was feeling and said if she needed to speak to him at any time he was carrying his mobile phone.

78. She said that she went back to the Health Care Centre and was asked by the Clinical Team Manager to start issuing tea time medications. She said, "I explained to her that I wasn't comfortable to do this but she explained to me that it had to be done so I went down to the pharmacy". She said that a more senior nurse who had returned from accompanying the woman to hospital, was unhappy seeing her doing medication and made her stop. They discussed what had happened and then updated the woman's clinical notes.

79. Nurse B said she was not aware if anyone had taken the matter up with the Clinical Team Manager subsequently but, in retrospect, she said that the Manager would have been trying to do the best for the prison and patients and might not have thought about the impact it had. Nurse B, who was distressed during the interview, said she had seen nursing staff leaving the prison at 4.30pm who had not been asked to extend their shifts. She felt it had been assumed she would just carry on working because she had already been scheduled to do an evening duty that day. She did not raise the matter at the hot debrief as having reflected on it, she felt that everybody might have been in a difficult position. She added that since the woman's death she had received a lot of support from her colleagues.

80. The investigator asked the Clinical Team Manager for her recollection of events that afternoon. She said she recalled several staff being distressed about what had happened to the woman. She said she did not order Nurse B to start the medication round, she had asked and she seemed quite happy to do it. The Manager thought they might have started it together. The other nurses on duty all had specific tasks to do such as reception duties and could not be moved. She added that asking staff if they would extend their shifts was not an uncommon task and she would do so if the situation warranted it. There was no spare capacity that evening because another nurse had accompanied the woman to hospital and Nurse A had injured herself while responding to the Code Blue. The Manager normally left work at 4.00pm but that day had finished at about 8.00pm. Nurse B began to give medication to the prisoners but then said she could not concentrate so the Manager said she should write up her notes and then go home. The nurse returned from the hospital and took over from her.

81. Styal’s Head of Healthcare visited the hospital at 8.30pm and spoke to the woman’s family to explain that there would be an opportunity for them to ask questions about her care at Styal.

82. After further neurological testing in the Intensive Care Unit, the woman’s family were given the bleak prognosis that there was no activity in her brain stem and it was highly unlikely that she would regain consciousness. Shortly after 6.00pm, with the agreement of the family, the life-support machine was turned off and she died with her family at her bedside.

83. The woman’s three former room mates were each told personally that she had died. However, the other residents of Davies House only found out when a Notice to Prisoners announcing her death was pinned to the communal noticeboard. Prisoner C described this as “horrible” and said it would have been nice if a member of staff had spoken to them personally. A member of the IMB visited Davies House on the morning of the woman’s death to talk to the staff and residents. She told a governor of her concerns that no officer was scheduled to be on duty there that evening and that the officer who was on duty at the time did not appear empathetic to the situation.

84. A memorial service in Styal for the woman took place at the same time as her funeral, so her friends in the prison could pay their respects. However, as prisoners were making their way to the Chapel at 1.30pm, a stand-fast roll check was called over the radio.

85. A stand fast roll check is a security measure to ensure that all prisoners can be accounted for at any given time. All prisoner movement is frozen across the prison, the number of prisoners in every area has to be counted and reported to the Orderly Officer (the most senior uniformed member of discipline staff responsible for responding to incidents within the prison that day). Styal’s security strategy requires that the orderly officer must call two random stand-fast roll checks a week but they have discretion over their timing.

86. Eventually at 2.00pm the service began. It was led by one of Styal’s Chaplain’s. He knew the woman as an outgoing person who occasionally attended religious services and a bible study group during the week. Her friends wrote a poem and signed a card for her family. In line with national Prison Service guidance assistance with funeral expenses was offered to her family.

Post mortem report

87. A post mortem examination was conducted by a Home Office pathologist. The findings of that examination noted that the causes of death were acute subarachnoid haemorrhage and ruptured saccular cerebral artery aneurysm (brain haemorrhage). A toxicology report concluded that neither alcohol nor drugs (other than methadone, diazepam and mirtazepine which were prescribed medication) were detected.

ISSUES

Clinical care

88. A review of the woman's medical care was commissioned from the local PCT and carried out by a clinical reviewer. He considered her clinical records, interviewed selected healthcare staff and undertook a literature review into the diagnosis and management of subarachnoid haemorrhage and migraine.

89. The woman's first reception health screen recorded that she was considered to be at low risk of self harm. Her history of substance misuse was correctly identified. The nature and extent of substance misuse was also identified and treated in an appropriate manner. The clinical reviewer noted that she did not have any particular problems with her physical health and that her headaches developed during her stay at Styal.

90. The clinical reviewer commented that the standard of entries in the clinical records was adequate and that there were no major issues in relation to communication between healthcare team members. He considered that the efforts made to resuscitate the woman were appropriate and adequate.

Establishing a diagnosis

91. After the woman first collapsed on 30 March, a nurse and the duty doctor discussed her case by telephone. The clinical reviewer commented:

> "It is apparent that there was no serious attempt made at establishing a diagnosis on this occasion. I am aware that this is a prison setting and there are often many false alarms, however, in general a "collapse" should be treated with due caution and respect."

92. The woman was seen by a locum doctor on 11 April, taking into account her history of headaches over the preceding week. The clinical reviewer comments:

> "The nature of the headaches is not described in the notes. There is no comment on the action that could or should be taken in relation to the 'other pathology'."

93. In his summary of his interview with Styal's GP, he continues:

> "It was noted that while the notes indicated two diagnosis were possible [?migraine ?another pathology] there was no proper explanation as to why the patient was treated only for migraine and further step/s not taken to explore the alternate pathology. It was also noted that the nature of the headaches experienced by the patient is not described in requisite detail.
>
> "The GP agreed that the diagnosis of migraine is essentially based on symptomatic history given by a patient and in this case the listed symptoms do not strongly point to a diagnosis of migraine.

> "The GP agreed that as the patient was considered to be suffering from migraine it resulted in another diagnosis not being actively considered."

94. Asked by the investigator whether the woman's condition would have been visible if she had a scan earlier, the clinical reviewer replied:

> "My view is that if she had a CT scan at the outset, it is very likely that an aneurysm [if present] would have been detected but reading the notes does not create an impression that a scan was definitely indicated. That is the reason that this case is not an easy one to assess. "

95. He considered that:

> "Staff placed undue reliance on the plausible but erroneous diagnosis of migraine. My view is that plans to meet [the woman's] healthcare needs were sufficiently comprehensive and robust on the basis that she suffered from migraine. However, the diagnosis of migraine was not based on a firm footing."

96. He offered an explanation of her headaches:

> "It should be noted that the patient's headaches were probably not due to a brain haemorrhage. The most likely explanation is that her headaches were due to an intra cerebral lesion [brain abnormality] which predisposed her to brain haemorrhage. However, it is possible that at the time she complained of headaches she had what is termed as "small leaks" from the cerebral lesion."

<u>Alternative diagnoses other than migraine</u>

97. The clinical reviewer gave his overall conclusion:

> "I take the view that [the woman] had a treatable condition which, if it had been diagnosed at an earlier stage, could have been amenable to treatment. However, it is not possible to take a more definitive view on this matter as this would have needed an expert pre-operative assessment.
>
> I further take the view that while a diagnosis of migraine was plausible and therefore not unreasonable, there were a number of indicators [patient wakes up with the headache. She was reported as saying that she had nausea when the headache was severe. She did not report any visual disturbance but said the back of her eyes ached …] which, had they been examined in a more critical manner, could have led to a different course of action being pursued."
>
> "My conclusion is that [the woman] received care which was timely and well intentioned. …However, it is also the case that while the issue of an alternative pathology was raised it was not pursued. One would have to say that in a purely technical sense [the woman's] condition was treatable and in that sense her death could have been prevented."

98. The clinical reviewer did not make any recommendations to the Primary Care Trust but does raise significant questions about shortcomings in the woman's treatment. He highlights the importance of careful analysis of headaches and associated symptoms. We are concerned that her severe symptoms were not further explored and therefore the opportunity for an intervention that might have saved her life was lost.

The Head of Healthcare should ensure that all healthcare staff are aware of the importance of careful monitoring and analysis of symptoms associated with headaches, so that all possible health conditions are considered and acted on, particularly when an alternative pathology has been indicated.

Other healthcare issues

99. The words "secreting diazepam 26.2.11" were written prominently at the front of the woman's prescription chart. They were not signed, initialled and no entries in her clinical record or other records referred to her misusing or having diazepam improperly. It is not even clear that the annotation related to her.

The Head of Healthcare should ensure that information on clinical records is appropriately entered and any actions recorded, so that full and accurate records are maintained.

100. Nurse B told our investigator she was asked by the Clinical Team Manager, following the woman being taken to hospital whether she would assist in issuing medication to prisoners. The Manager said she did not have any other staff who could perform the task and thought the nurse had been happy to do it. We do not know what exactly was discussed between the two but the nurse was left feeling distressed that her feelings had been overlooked, whereas the Manager was certain she had been supportive and that she urged her to go home when it was clear that she could not continue. Staff involved in a traumatic event should be appropriately supported and it is clear that the nurse was distressed and felt unsupported by her manager at the time.

The Head of Healthcare should ensure that all healthcare managers provide effective support to their staff when they have been involved in a serious incident.

101. We are concerned about the number of occasions when some healthcare staff appeared unresponsive and did not appear to demonstrate a caring approach. One officer told us how she met with apparent indifference from the nurses when she went personally to healthcare to try to arrange an emergency appointment for the woman. Both nurses involved were unable to recall this event when interviewed. We were told by women prisoners of an incident where it is claimed a nurse wrote 'so sue me' in a speech bubble on an article about medical negligence. Other women were shocked at what they saw as the nurses' apparent lack of urgency when attending the Code Blue emergency on 26 April when one allegedly said 'it's only a headache'. We accept that not all of these incidents are fully corroborated but there are

too many to ignore. We also take into account that our investigator encountered an unhelpful attitude from some healthcare staff. In the circumstances we feel there is sufficient concern for the Governor and Head of Healthcare to investigate these matters internally.

The Governor and Head of Healthcare should ensure that healthcare staff are appropriately selected, supported and trained to work in a prison setting and demonstrate appropriate levels of professional care which ensure that the needs of their patients are always put first.

Issues raised by the woman's family

Was the woman's health sufficiently assessed?

102. The woman's mother queried whether her daughter's health had been assessed sufficiently. In her letter to her mother, she said it had taken two weeks to see a doctor after her collapse on 30 March. Her clinical record shows that a nurse consulted the duty doctor about her care and condition by telephone that day. However, as the clinical reviewer pointed out, there was little effort by the doctor to explore the reasons behind her collapse. When she continued to experience headaches at the back of her head, the nurse referred her for an urgent GP appointment on April 9 but, for reasons that are not apparent, she was not seen by the doctor that day. She was not seen by a doctor until 11 April, 12 days after her first collapse. We do not think this is acceptable. The clinical reviewer concluded that there were attempts to assess her healthcare needs but because the diagnosis was mistaken, repeated contact with nursing staff did not improve her condition markedly because it was "known", erroneously, that she was experiencing migraines. HM Inspectorate of Prisons and the IMB have also raised concerns about the length of time women at Styal have to wait for GP appointments.

The Head of Healthcare should review the current arrangements for GP appointments to ensure that waiting times are equivalent to those in the community.

Should the woman have been taken to hospital earlier?

103. The woman's mother questioned why her daughter was not taken to hospital earlier. After an officer had raised a Code Blue at 10.55am on 26 April on learning from Prisoner B that she had lost consciousness in the bathroom, Nurse A's clinical notes of 11.28am said her headaches were "increasingly worse" than at the previous weekend and she said she wanted to go to hospital. The clinical reviewer commented:

> "She was reviewed by the doctor at 12.01. On balance, I take the view that decision to observe the patient could be defensible. However, it is also the case that in light of the stated symptoms and detected signs, the case for a referral is also evident."

104. Clearly the arguments appear at first to be finely balanced. If however, the officer's enquiries at the Healthcare Centre earlier that morning on the woman's behalf had been followed up by the nurses she spoke to, the

woman's clinical records would have been appropriately updated. In which case the GP would have had the information that she had already vomited in the television room and the toilet, she had been holding her head in sudden pain and crying. In the event, the officer was told that the appointment list was full. She was not asked which prisoner was unwell, what symptoms they had, nor was she advised what she should do in the meantime.

105. This was valuable information which was lost to the healthcare team as there did not appear to be a process, short of calling a medical emergency for identifying and seeing prisoners who are unwell but cannot get a doctor's appointment. The healthcare induction material says that an officer will contact the Healthcare Centre for assistance. However, when the officer did so, it was left to her to work out what to do next in the absence of a process for escalating concerns.

106. We appreciate that the doctor and triage appointments were fully booked that day. Also, we understand Nurse B's situation who, on her first day working in the Healthcare Centre, found herself overloaded with a number of tasks, each one competing for time with the next. However it is unacceptable that such an urgent healthcare concern was left unattended.

The Governor and the Head of Healthcare should ensure that officers and non-clinical staff know how to raise an urgent healthcare concern about a prisoner, so that unnecessary delays in treatment are avoided.

107. At the consultation stage of this report, the NHS Trust expressed the view that staff were well supported by the Head of Healthcare and other senior healthcare managers. They spoke of the positive feedback he had received from a range of colleagues and felt that he should have been interviewed specifically as part of the investigation. They viewed the differences in accounts between nursing staff and officers as lacking corroboration and regarded the recommendation about a system for raising an urgent healthcare concern as 'poorly substantiated'. We have considered their response and are satisfied that the recommendations arising from this investigation should remain unchanged.

108. We also have concerns about the operation of the emergency response radio message at Styal. An officer alerted the communications room to a "Code Blue" situation at 3.27pm. She was told that the healthcare emergency responder was on their way. The officer issued a second Code Blue message which another officer responded to and arrived just before the nurse, who at 3.31pm asked for the doctor to attend. An ambulance was not called until 3.37pm yet the situation was clearly an emergency.

109. In several previous investigation reports, we have highlighted the issue of requesting an ambulance when a medical emergency has been raised. A Department of Health protocol between local Ambulance Trusts and National Offender Management Service concerning when an ambulance should be called has been in existence since 2004 and was updated in 2006. In addition in February 2011, following a report published by this office, a letter to all Governors was sent jointly by the Chief Executive Officer of the National Offender Management Service and the Director of Offender health asking for

all existing ambulance protocols to be immediately reviewed to ensure that effective emergency access is available in all establishments, the letter states:

> "It is also essential that internal procedures should not waste undue time in summoning emergency assistance. It should not, for example, be a requirement in every case for a member of the prison healthcare team to attend the scene before the emergency services are called."

110. Any member of staff raising the alarm should be able to call for an ambulance. It is unnecessary to wait until a healthcare professional arrives to assess whether one is needed as valuable minutes can be wasted.

The Governor should ensure that internal procedures do not lead to delays in summoning an emergency ambulance and that all staff understand and follow the guidance in the letter of February 2011 from NOMS and Offender Health.

111. Had an ambulance been requested at 3.27pm after the officer's first code blue message, another ambulance already in Styal's grounds to attend to an unwell child in the visits area might have been deployed to better effect. As it turned out not to be needed, it left Styal at 3.34pm, only for an ambulance to be called for the woman at 3.37pm. Regrettably, although the Ambulance Service despatched their nearest available ambulance, it was some miles from the prison and did not arrive at the gate until 3.59pm – some 21 minutes after it was sent. As a result of enquiries made by our investigator, the Ambulance Service discovered that an ambulance service car was available but it was not sent to Styal, which contributed towards the delay. The Ambulance Service held an internal investigation of the matter and took internal action against the despatcher concerned.

Breaking the news of the woman's death to residents

112. Most residents of Davies House did not get to know of the woman's death until they saw an officer putting up a Notice to Prisoners on a communal noticeboard announcing it. Prisoner C described this as "horrible." On the day of the woman's death, a member of the Independent Monitoring Board raised concerns with a governor that the officer who was on duty on Davies House did not appear to show empathy for the women who had experienced such a traumatic event. During our investigator's opening visit, the Deputy Governor readily accepted that the way news of the death had been broken had lacked a personal touch and, with hindsight, a more considered approach would have been preferable.

113. This poor handling was compounded by the orderly officer calling a stand-fast roll check at the time of Styal's memorial service for the woman. We understand the importance of such checks in prisons but as the orderly officer has discretion when to implement such exercise, it was insensitive in the extreme that the effect it would have on staff and prisoners who were finding it difficult to come to terms with her sudden death did not appear to have been considered. It was also disrespectful to her memory.

The Governor should ensure that prisoners are informed of a death in custody in a sensitive and supportive way, and that those who wish remember the person at a communal gathering should be able to do so with appropriate dignity and respect.

CONCLUSION

114. The woman was a young woman who appears to have been determined to use her time in prison to turn her life around. She was popular with staff and prisoners alike.

115. She had been in prison for around three months when she began to suffer with severe headaches. She was seen by healthcare staff and a mis-diagnosis of migraine appears to have been made and treatment given.

116. Sadly, there was no further exploration of her headaches and other associated symptoms (such as vomiting and a previous collapse). On 26 April she was found by a room mate in an unconscious state and subsequently died the following day in hospital from a brain haemorrhage.

117. The clinical reviewer raises a number of significant questions about shortcomings in her treatment.

118. We are concerned about a number of aspects of her care and have made eight recommendations in relation to this. It is indeed worrying that the clinical reviewer says that "in a technical sense her condition was treatable and in that sense her death could have been prevented".

119. We are also concerned about the reported attitude of some healthcare staff which does not give confidence of a caring approach and the unnecessary delay in the calling and the arrival of an ambulance.

120. We believe that she was not well served in relation to aspects of her health and emergency care, and hope that the recommendations we make will make a difference to future healthcare and treatment at HMP Styal.

RECOMMENDATIONS

The National Offender Management Services response is noted in italics below each recommendation.

1. The Head of Healthcare should ensure that all healthcare staff are aware of the importance of careful monitoring and analysis of symptoms associated with headaches, so that all possible health conditions are considered and acted on, particularly when an alternative pathology has been indicated.

   This recommendation was accepted. 'A formal teaching session is planned, facilitated by a clinical specialist, in the considerations required when caring for a patient complaining of headaches. This will be supplemented by a clinical case review session where the clinical notes of a relevant case will be presented and reviewed against best practice.'

2. The Head of Healthcare should ensure that information on clinical records is appropriately entered and any actions recorded, so that full and accurate records are maintained.

   This recommendation was accepted.

3. The Head of Healthcare should ensure that all healthcare managers provide effective support to their staff when they have been involved in a serious incident.

   This recommendation was accepted. The NHS Trust considers that appropriate systems and processes are in place to ensure that staff are supported following a serious incident. These were followed in principle, however we note that there is a difference of perception between the nurse and the Clinical Manager. As an organisation, the NHS Trust is committed to continuously learning from incidents and feedback. They have re-issued their policies, communicated to staff that their emotional health and well being is paramount and reaffirmed they have a personal responsibility to raise concerns so that they can receive support.

4. The Governor and Head of Healthcare should ensure that healthcare staff are appropriately selected, supported and trained to work in a prison setting and demonstrate appropriate levels of professional care which ensure that the needs of their patients are always put first.

   This recommendation was accepted. 'All healthcare staff are recruited via the established NHS Code of Practice that includes a vigorous selection and checking procedure. There is little corroborative evidence in either the Clinical Review or the PPO report and its appendices to indicate that issues relating to recruitment and training substantially contributed to this case.'

5. The Head of Healthcare should review the current arrangements for GP appointments to ensure that waiting times are equivalent to those in the community.

This recommendation was accepted. 'Plans are at an advanced stage to recruit to the GP body an additional 10-15 hours of GP time per week … It is hoped that new staff will be in place by September 2012. In the meantime, the NHS Trust's current practise remains that a small number of appointment slots are protected within each clinic until the day of that clinic so that cases deemed as urgent can be accommodated …'

6. The Governor and the Head of Healthcare should ensure that officers and non-clinical staff know how to raise an urgent healthcare concern about a prisoner, so that unnecessary delays in treatment are avoided.

   This recommendation was accepted. 'If any members of staff have concerns about a given situation that they feel is not being addressed, then these can be readily escalated to either the prison Principle [sic] Officer of the day (the officer site manager) or the Duty Healthcare Manager. Both managers are easily accessible via the prison radio network.'

7. The Governor should ensure that internal procedures do not lead to delays in summoning an emergency ambulance and that all staff understand and follow the guidance in the letter of February 2011 from NOMS and Offender Health.

   This recommendation was accepted. 'The prison works within the protocol for the Ambulance Service and will re-enforce this to appropriate staff through established communication channels. This protocol states that the first person on scene may call an ambulance via the prison control room if they deem this necessary.

8. The Governor should ensure that prisoners are informed of a death in custody in a sensitive and supportive way, and that those who wish remember the person at a communal gathering should be able to do so with appropriate dignity and respect.

   This recommendation was accepted. 'Following a death in custody, a manager will be identified through contingency planning to ensure that prisoners are personally informed of any death by prison staff wherever possible and that this is carried out in a sensitive and supportive manner with women offered support wherever required. On the day of the chapel service, the orderly officer made the decision to call a steadfast roll check, which he expected to be completed before the service commenced. The steadfast roll check was cancelled as soon as the orderly officer realised this may affect the service. Orderly officers will be instructed to ensure that wherever operationally possible, the regime of the prison is managed to ensure that such services are prioritised within the regime.'