A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a woman in March 2014, while in the custody of HMP Styal

Our Vision

*'To be a leading, independent investigatory body,
a model to others, that makes a significant contribution
to safer, fairer custody and offender supervision'*

This is the investigation report into the death of a woman who died in March 2014, while in the custody of HMP Styal. The woman died of a restriction of the blood supply in her leg, a blood clot in her leg and lung cancer that had spread to her other organs. She was 67 years old. I offer my condolences to the woman's family and friends.

The investigation was carried out by an investigator. A clinical reviewer reviewed the clinical care the woman received at HMP Styal. The prison cooperated fully with the investigation.

The woman was sentenced to nine years imprisonment in 2011 and sent to HMP Styal. She had a number of health problems including diabetes, asthma, chronic obstructive pulmonary disease, hypertension and a heart disorder. Healthcare staff saw her frequently in relation to her medical conditions. In January 2014, the woman experienced pain in her leg and a doctor referred her to hospital. Tests showed she had a deep vein thrombosis in her leg and the hospital prescribed anticoagulant injections for healthcare staff at the prison to administer daily.

In February, a prison GP was concerned about the woman's condition and she was admitted to hospital that day. Tests showed that she had life threatening ischaemia in her leg (restriction of blood supply to the tissues) and lung cancer. The woman remained in hospital until she died.

The woman had a number of serious medical conditions and the clinical reviewer considers that much of her clinical care at the prison was satisfactory. However, it is a serious concern that the woman did not receive the daily anticoagulant medication prescribed to treat her deep vein thrombosis. While it appears that she often did not attend the prison's healthcare centre for the injections, there is no record that this was followed up to establish the reasons or to explain the importance of taking the medication. The clinical reviewer considers that this could have contributed to the deterioration in her condition and, as a result, her care was not equivalent to that she could have expected in the community. I am also concerned that, until hospital staff requested its removal, the woman was restrained by an escort chain in hospital without appropriate and regularly reviewed risk assessments which fully took into account her condition.

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 **September 2014**

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SUMMARY

1. The woman was sentenced to nine years in prison on 20 October 2011 and sent to HMP Styal. During her initial health screen, the woman said she was waiting for hip surgery, had suffered from depression, was type 2 diabetic and asthmatic, and had a history of chronic obstructive pulmonary disease (COPD), hypertension and a heart disorder. She smoked cigarettes.

2. Healthcare staff saw the woman frequently in relation to her medical conditions and she attended hospital a number of times with exacerbation of COPD and to stabilise her blood sugar levels. She had regular podiatry and optical assessments in relation to her diabetes.

3. On 31 January 2014, a prison GP suspected the woman had deep vein thrombosis (DVT) when she reported pain in her leg. He sent her to hospital where she was treated for a DVT and returned to prison that day. The hospital prescribed anticoagulant injections which healthcare staff would administer daily. Records show that the woman did not attend for her injection every day but there is no evidence that healthcare staff followed this up.

4. On 24 February 2014, a prison GP examined the woman and noted that her leg had swollen substantially and she was in considerable pain. The GP arranged for the woman to be admitted to hospital where tests showed that she had a life threatening blood clot in a leg artery. A CT scan also revealed that she had lung cancer which had spread to other organs. The woman remained in hospital and her condition steadily deteriorated.

5. The woman was restrained by an escort chain until 2 March, when hospital staff asked for the chain to be removed as it was impeding her treatment. On 4 March, the Governor released the woman on temporary licence. Her health continued to deteriorate and she died in hospital on 8 March.

6. The investigation found that the woman did not receive all the anticoagulant injections as prescribed. The clinical reviewer considers that this could have contributed to the deterioration in her condition and her care was therefore not equivalent to that she could have expected to receive in the community. We are also concerned that the woman was restrained without a properly considered risk assessment when she was in hospital. We make two recommendations.

THE INVESTIGATION PROCESS

7. The investigator issued notices to staff and prisoners at HMP Styal informing them of the investigation and inviting anyone with relevant information to contact her. No one responded.

8. The investigator obtained copies of the woman's prison medical records and relevant extracts from her prison record.

9. NHS England commissioned a clinical reviewer to review the woman's clinical care at the prison.

10. We informed HM Coroner for Cheshire of the investigation, who provided the cause of death. We have sent the Coroner a copy of this investigation report.

11. One of the Ombudsman's family liaison officers contacted the woman's husband, her nominated next of kin, to explain the investigation. He said that the woman had been concerned that she had missed hospital appointments.

12. The woman's family received a copy of the draft report. They did not raise any further issues or comments on the factual accuracy of this report. The prison considered our draft report and recommendations, which they have accepted. The prison has also submitted an action plan in respect of our recommendation, which is included at the end of this report.

HMP STYAL

13. HMP Styal is a closed prison in Wilmslow, Cheshire for up to 460 women. There are a variety of residential units, with 16 separate houses holding about 20 women and a mother and baby unit. There is also a wing holding up to 134 women.

14. Spectrum Community Health provides healthcare services at the prison. There are nurses on duty at all times with a minimum of two registered nurses and a health support worker at night. There are daily GP sessions except Sundays when there is an out of hours service. There are specialist clinics for sexual health, long term conditions, dental and medical health. There is no in-patient facility.

HM Inspectorate of Prisons

15. The most recent inspection of HMP Styal was in July 2011. Inspectors found that there were daily GP clinics, but routine appointments took too long. A high proportion of women received medication which made it difficult to administer it safely. Chronic disease management was largely ad hoc. General health promotion was good and pharmacy arrangements had improved. There were gaps in services for women with mental health problems.

Independent Monitoring Board

16. Each prison in England and Wales has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community, who help ensure that prisoners are treated fairly and decently. In its most recently published report for the year to March 2013, the IMB noted that all new prisoners had a health screen within 24 hours of arrival and all new admissions with medical needs had a treatment and care plan. The Board said that the appointment process worked well and compared favourably with community provision.

Previous deaths at HMP Styal

17. The woman was the second prisoner at Styal to die from natural causes since the start of 2011. There are no significant similarities with the previous case.

KEY EVENTS

18. The woman was sentenced to nine years in prison on 20 October 2011 and sent to HMP Styal. At the time of her sentence she had already been diagnosed with type 2 diabetes, asthma, chronic obstructive pulmonary disease (COPD – lung disease), hypertension (high blood pressure) and a heart disorder. She wore a hearing aid, was obese, was a moderate cigarette smoker and was on a waiting list for a hip replacement. She had a history of depression and had suffered a heart attack some time previously.

19. Healthcare staff saw the woman frequently in relation to her medical conditions. She attended hospital a number of times with exacerbation of COPD and to stabilise her blood sugar levels. She had regular podiatry and optical assessments in relation to her diabetes and was given advice to encourage and help her give up smoking.

20. On 14 January 2014, a locum GP examined the woman who had pain in her right leg. He noted that there was no evidence of a deep vein thrombosis (DVT – a blood clot in a deep vein, usually in the legs) and prescribed ibuprofen gel as pain relief.

21. On 31 January, a prison GP examined the woman who said that she that the pain in her leg was worse. The doctor suspected she had DVT and arranged for her to go to hospital that day. At hospital, she was treated for DVT and discharged the same day. The hospital prescribed clexane injections (anticoagulant) to treat the DVT and prevent further clots. The woman needed to attend the healthcare centre every day to receive the injections. Records show on some occasions she had difficulty attending as she complained of feeling lethargic, vomiting, with pain and swelling in her foot. However, most of the time, there is no record of the reasons why she did not attend and the woman did not receive all the injections as prescribed.

22. On 16 February, a nurse went to see the woman because she had been unwell and unable to attend the healthcare centre for her DVT injection. The nurse also noted that the woman's blood pressure was high and advised her to rest.

23. On 22 February, a locum GP saw the woman and noted her right big toe had poor circulation. He noted that she had not been attending healthcare for her anticoagulant injection. He made an urgent request for blood tests and referral to the vascular surgeon. The doctor asked for the woman to be reviewed after three days,and stressed that she should continue with the anticoagulant.

24. At 11.44am on 24 February 2014, the record shows that officers contacted the healthcare centre and said that the woman was not well enough to attend for a blood test. A nurse went to see her and noted that the woman was pale and lethargic and her right leg and foot was purple. Her pulse was weak. She asked the doctor to see the woman urgently and a prison GP, saw the

woman later that day. The GP noted that her leg had swollen from her groin to her foot, it was discoloured and she was in considerable pain. She arranged for the woman was go to hospital that day. The woman was restrained by a single handcuff on the journey and an escort chain was used at the hospital. (An escort chain is a long chain with a handcuff on each end, one of which is attached to the prisoner and the other to an officer.)

25. The woman was admitted to hospital and tests revealed that she had a life threatening blockage to an artery in her leg. Surgeons decided that surgery was not possible and she was treated with intravenous fluids and antibiotics. The woman had a CT scan of her chest, abdomen and pelvis, which revealed she had lung cancer that had spread to other organs. The woman remained in hospital and her condition deteriorated. At 8.30am on 2 March, the escort chain was removed after hospital doctors said it was impeding the woman's care. It was not used again.

26. On 4 March, the Governor withdrew the escorting officers and released the woman on temporary licence, as she was very ill and not mobile. A prison family liaison officer and the orderly officer visited her each day. The prison also arranged for one of the woman's friends from the prison to visit her. The woman's condition continued to deteriorate and she died at the hospital at 4.35pm on 8 March.

Liaison with the woman's family

27. On 2 March, a prison family liaison officer visited the woman in hospital and explained his role. The woman asked him to let a friend of hers know that she was in hospital. The family liaison officer visited her friend and informed her that day.

28. On 2 March, the duty governor at Styal contacted HMP Dovegate, where the woman's husband was detained, to inform them of the situation. Staff at Dovegate informed the woman's husband and arranged for him to speak to his wife by telephone the same day. Arrangements were begun for the woman's husband to visit his wife in hospital, but these were not finalised before she died.

29. After the woman died, the chaplain at Dovegate informed the woman's husband and the family liaison officer contacted her friend to let her know. The family liaison officer visited the woman's husband on 10 March to offer his condolences and discuss the funeral arrangements. The prison arranged and paid for the woman's funeral.

Support for staff and prisoners

30. A Governor's notice informed staff and prisoners of the woman's death and offered support to anyone affected. Prisoners identified as at risk of suicide and self-harm were reviewed in case they had been adversely affected by the news of the woman's death.

Cause of death

31. The medical report from Wythenshawe Hospital said that the woman died from critical ischaemai lower limb (a severe blockage in the arteries in her leg), lower limb DVT, metastatic primary pulmonary adeocarcinoma (lung cancer) and pulmonary embolism (blocked artery).

ISSUES

Clinical Care

32. The clinical reviewer says that the woman's long term conditions of COPD and diabetes were well managed and she had appropriate eye and foot care in line with national diabetes guidelines. He makes several recommendations about healthcare issues which the head of healthcare will need to address

33. The clinical reviewer is satisfied that the initial response to the woman's leg pain was appropriate. However, he is concerned that she did not appear to receive all her anticoagulant medication and this could have impacted on her condition.

The woman's anticoagulant injections

34. On 31 January, the hospital prescribed the woman daily clexane injections. She went back to the prison that day and the records show she was expected to attend the healthcare centre each day to get her injection. The medical records are not clear, but it appears that the woman often did not attend. However, there is only one recorded occasion when a nurse went to see her to give the injection. There is no record that anyone followed up with the woman the reasons why she was not attending to receive her injections. Prisoners have the right not to accept medical treatment, but we are concerned that the woman may not have attended because she felt too unwell and there is no record that this was checked. .

35. Anticoagulant therapy is vital in the treatment and control of DVT and this is clearly set out in National Institute for Health and Care Excellence (NICE) guidance. It is concerning that the woman did not appear to receive this as prescribed. The clinical reviewer examined the records and could only find 14 times recorded in a period of 24 days when the woman received the injection. On the other dates there were no signed administration sheets to confirm the injection was given. On 22 February, the GP noted that the woman was not attending the healthcare centre to receive her injections. The clinical reviewer said that the lack of regular anticoagulant would have impacted on her condition and could have resulted in the deterioration of an existing DVT and allowed the development of further clots. As the prescribed injections were not administered regularly, the clinical reviewer does not consider that the woman received care equivalent to that which she could have expected in the community. We make the following recommendation:

    The Head of Healthcare should ensure that there are effective processes to ensure that prisoners receive medication as prescribed and that failure to attend to collect medication is followed up with the reasons recorded. Where prisoners decline to accept medical treatment they should be asked to sign a disclaimer.

Hospital appointments

36. The woman's husband was concerned that she had missed several hospital appointments. We have examined the medical records, which show that she attended all of her scheduled medical appointments and was taken to hospital when prison doctors were concerned about her condition. There was one occasion, on 26 June 2013, when the hospital cancelled an appointment, but rescheduled this for 3 July. She attended the rescheduled appointment without difficulty.

Restraints, security and escorts

37. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital, and a responsibility to balance this by treating prisoners with humanity and maintaining their dignity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment which considers the risk of escape, the risk to the public and which also takes into account factors such as the prisoner's health and mobility. A judgement in the High Court in 2007 made it clear that a distinction needs to be made between the risk of escape (and the risk to the public in the event of an escape) posed by a prisoner when fit and those risks posed by the same prisoner when suffering from a serious medical condition. The judgement indicated that medical opinion about the prisoner's ability to escape must be considered as part of the assessment process. It also deemed that restraining by handcuffs of a prisoner receiving chemotherapy (and by implication, other life saving treatment) was degrading and that such restraint would be likely also to be regarded as inhumane unless justified by other relevant considerations. The judgement considered that the conditions of restraint applied during a prisoner's stay at hospital should be assessed separately from the conditions of restraint used on escort and should be reviewed frequently or when circumstances changed.

38. On 24 February, when the woman was taken to hospital, she was pale and lethargic, she had extensive swelling from her groin to her foot and she was in considerable pain. She was assessed as a high risk to the public due to the nature of her offence (although the circumstances would suggest that high risk to the public was unlikely). All other risks were considered low. The medical part of the risk assessment said there were no medical objections to restraints being used, but did not give any information on her condition or whether her condition impacted on her risk of escape as the High Court judgement requires. An operational manager authorised the use of single cuffs for the journey to the hospital and an escort chain when she arrived there. The woman was to be accompanied by two officers at all times, one of whom had to be female.

39. There is no record that the risk assessment for restraints was reviewed again when she was admitted to hospital and there was no further review until 2 March. The escort chain was then removed at the request of hospital staff as it was impeding the woman's treatment, not because the prison had reviewed

the need for restraints. At the time the woman was immobile and located in a side room of the ward.

40. The Prison Service has a fundamental responsibility to protect the public, but security must be balanced with humanity and measures must be proportionate to a prisoner's individual circumstances. We are not satisfied that the risk assessment fully considered and took into account the woman's risk and condition or that it was reviewed with sufficient frequency to take into account her declining condition. It is not sufficient for healthcare staff simply to say that there are no medical objections to the use of restraints. There needs to be active consideration of how a prisoner's health and mobility impacts on his or her risk of escape as required by the 2007 High Court judgement. Ultimately, it is the Governor's responsibility to ensure that the process is managed properly, but the Head of Healthcare needs to ensure that healthcare staff understand their responsibilities and have appropriate input into the risk assessment process. We make the following recommendation:

The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position, that assessments fully take into account the health of a prisoner, are based on the actual risk the prisoner presents at the time and frequently reviewed.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that there are effective processes to ensure that prisoners receive medication as prescribed and that failure to attend to collect medication is followed up with the reasons recorded. Where prisoners decline to accept medical treatment they should be asked to sign a disclaimer.

2. The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position, that assessments fully take into account the health of a prisoner, are based on the actual risk the prisoner presents at the time and frequently reviewed.

ACTION PLAN

No	Recommendation	Accepted/Not accepted	Response	Target date for completion and Function Responsible	Progress (to be updated after 6 months)
1	The Head of Healthcare should ensure that there are effective processes to ensure that prisoners receive prescribed medication as prescribed and that failure to attend to collect medication is followed up with the reasons recorded. Where prisoners decline to accept medical treatment they should be asked to sign a disclaimer.	Accepted	A full and comprehensive audit of all aspects of medicine administration, including those issues identified in the recommendation, will be undertaken. Resulting actions will be developed into an action plan, which will be monitored via the medicines management group and monthly clinical governance meetings.	Head of Healthcare, Healthcare Matrons. 30 September 2014	