PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a woman in April 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 from sepsis in April 2014, while a prisoner at HMP Styal. She was 50 years old. I offer my condolences to her family and friends.

A clinical review of the care the woman received at HMP Styal was undertaken. The prison cooperated fully with the investigation.

The woman was sentenced to four years in prison in June 2012 and went to HMP Styal. She had a number of chronic health problems including atrial fibrillation and myotonic muscular dystrophy. Healthcare staff saw her frequently to manage her medical conditions.

On 27 April 2014, a nurse examined the woman after she complained of right sided chest pain, shortness of breath and sickness. The nurse requested an ambulance and she was taken to hospital. She continued to deteriorate and died a few days later.

I agree with the clinical reviewer that the woman did not receive a good standard of healthcare at Styal. Healthcare staff do not appear to have recognised or managed the health risks arising from her muscular dystrophy and poor nutrition. This meant that opportunities to identify her poor respiratory function were also missed. I am also concerned that the prison restrained a seriously ill, low risk prisoner until a hospital doctor asked prison officers to remove the restraints without an adequate assessment of her risk.

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 **December 2014**

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SUMMARY

1. On 15 June 2012, a judge sentenced the woman to four years in prison for causing death by dangerous driving. She went to HMP Styal.

2. The woman had suffered poor health for many years and had several long term medical conditions including atrial fibrillation (a fast and erratic heart beat) and myotonic muscular dystrophy (a progressive muscle wasting condition). At her initial health screen she told the nurse that she took drugs and had been prescribed methadone before coming to prison. She admitted illicit use of heroin and said she was depressed after the death of her partner.

3. Healthcare staff monitored the woman's conditions. She attended many hospital appointments and had blood tests, scans and X-rays. In August 2012, she was diagnosed with hepatitis C and began treatment. The same month, she completed a methadone detoxification programme.

4. On 15 April 2014, a prison GP examined the woman after she complained of headaches, pressure in her head and neck and abdominal pains. He prescribed lansoprazole (to reduce stomach acid), mebeverine (to relieve muscle cramps/irritable bowel) and paracetamol. The results from a blood test were within the normal range.

5. On 27 April, the woman told an officer she had been sick, was sweating and her chest ached. Two nurses examined her and found she was short of breath, and her oxygen levels were low. The nurses requested an ambulance and administered oxygen until paramedics arrived.

6. The woman went by ambulance to hospital. Two officers accompanied her and restrained her by handcuffs. The officers removed the handcuffs when a hospital doctor asked them to, a few hours after she was admitted to hospital.

7. The woman remained in hospital and the prison released her on temporary licence. In hospital, her condition continued to deteriorate and she died at 7.20am on 29 April. A post-mortem revealed she had died from sepsis (a whole body inflammation caused by severe infection) due to bronchopneumonia and neutropaenia, a blood disorder.

8. The clinical reviewer concluded that the care provided at HMP Styal was not equivalent to that expected in the community. She has made a number of recommendations that the Head of Healthcare will need to address, including improving the management of prisoners with chronic and complex diseases and the use an appropriate screening tool for all prisoners who might be at risk of malnutrition. We are concerned that the prison restrained the woman when she went to hospital without proper justification. We make three recommendations.

THE INVESTIGATION PROCESS

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

10. The investigator obtained copies of the woman's prison medical records and relevant extracts from her prison record. He visited Styal on 2 May 2014 and spoke to her roommate and prison and healthcare staff. On 12 June he interviewed a nurse at the prison and gave the deputy governor initial feedback about the preliminary findings of the investigation.

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

12. We informed HM Coroner for Cheshire, Halton and Warrington of the investigation, who provided the post-mortem report. We have sent the Coroner a copy of this investigation report. This investigation was suspended until 23 July 2014, when we received toxicology results.

13. One of the Ombudsman's family liaison officers contacted the woman's sister, her nominated next of kin, to explain the investigation. She did not have any specific issues for the investigation to consider but said she had been surprised that the prison had difficulties contacting her after her sister's death as there were up to date contact details in her letters to her sister. She received a copy of the draft report. She did not make any comments. The prison has also submitted an action plan detailing what they have done to address the issues we raised and this is included at the end of the report

HMP STYAL

14. 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 each holding about 20 women. There is also a mother and baby unit and a wing holding up to 134 women.

15. Spectrum Community Health runs 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 mental health. There is no in-patient facility.

HM Inspectorate of Prisons

16. The most recent inspection of 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. (Since the time of the 2011 inspection, responsibility for the provision of healthcare services has changed as have a number of the systems and processes.)

Independent Monitoring Board

17. 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 recent report for the year to March 2013, the IMB noted that all new prisoners had a health screen within 24 hours of arrival and new admissions with medical needs had a treatment and care plan. The IMB said that there was an appropriate system to deliver healthcare services. Expected GP appointment waiting time for most prisoners was five days and some slots were kept each day for urgent appointments.

Previous deaths at HMP Styal

18. The woman was the third prisoner at Styal to die from natural causes since the start of 2011. There has been one death since. There were no significant similarities with the other deaths, but we have identified the need for appropriate use of restraints before.

KEY EVENTS

19. On 15 June 2012, the woman was sentenced to four years in prison for causing the death of her long-term partner by dangerous driving. She had not been to prison before. At an initial health screen, a nurse noted she had a number of physical health problems, including atrial fibrillation (an abnormal heart rhythm), myotonic muscular dystrophy (a weakness and wasting of the muscles), sleep apnoea and a damaged and repaired spleen. She said she had used heroin from the age of 16 and that she had a daily community prescription of methadone. (She continued to receive methadone in prison.)

20. The woman's other medications were sotalol (to treat irregular heart beats and hypertension), aspirin and simvastatin (to lower cholesterol). She had been prescribed an antidepressant (mirtazepine) a few months before she came into prison, but said she had not taken it. She had pre-arranged hospital appointments for cardiology and neurology treatment, which she attended as planned. She said she smoked up to nine cigarettes a day, but did not want help and advice about stopping smoking. A nurse arranged a mental health assessment and, over the following months, she saw someone from the mental health inreach team for bereavement counselling. Healthcare staff agreed a care plan to manage her conditions.

21. Throughout the rest of 2012, healthcare staff saw the woman frequently to monitor her heart condition and muscular dystrophy, and records show her mobility steadily declined. The substance misuse team monitored her and gradually reduced her methadone treatment dose. She tested positive for hepatitis C (liver disease) and a doctor referred her to a liver specialist at hospital.

22. On 5 March 2013, the woman began a 24 week treatment plan for hepatitis C. During the treatment, her appetite declined and a doctor prescribed nutritional drinks. On 18 March, a prison GP examined her, who had a dry and bleeding mouth. He requested blood tests, which indicated anaemia and a bacterial infection, and prescribed an antibiotic and iron supplement. The GP referred her to a gastroenterologist, who saw her on 25 April.

23. On 10 July, the woman told a nurse that she had had been suffering constant headaches for two weeks and that she had a lump on the right side of her neck. The nurse referred her to the GP to examine the lump. The next day, she saw a nurse for hepatitis treatment and reported the same symptoms. The nurse did not consider the symptoms were side effects of her hepatitis treatment and referred her to a GP. A prison GP saw her on 17 July and prescribed co-codamol for her headaches.

24. On 2 August, the woman told a nurse that she had been suffering from headaches for the last six weeks that were getting worse. She said she had muscular neck pain and black flashes in her vision. Her mouth was dry and she was constantly thirsty, although she said she drank plenty of water. The nurse arranged an emergency GP appointment and a prison GP saw her

about an hour later. He noted that an optician had examined her two weeks before and the results had been normal. He diagnosed stress related headaches and prescribed naproxen (used to treat pain/inflammation).

25. The woman completed treatment for hepatitis on 20 August but told a nurse that she still had headaches. The nurse said that headaches were common side effects of the treatment and should stop now that it had finished. On 2 September, she told a nurse that her headaches were no better. The nurse referred her to the GP. The GP saw her two days later and diagnosed possible retinal detachment.

26. On 5 September, the woman went to hospital, where an examination showed she did not have a retinal detachment. When she returned to the prison a GP examined her, who said she had stomach pains. He prescribed mirtazapine (an antidepressant), sotalol and trimethoprim (an antibiotic). On 17 September, a nurse informed her that her blood results for hepatitis C were negative. She told the nurse her headaches persisted.

27. On 2 October, a GP prescribed more trimethoprim when the woman reported back and stomach pain. On 1 November, she told a prison GP that she had an ache in her back at night. Blood and urine test results were normal and the doctor recommended pelvic floor exercises. She continued to complain of lower back pain throughout November.

28. On 12 December, a prison GP examined the woman, who said she had back pain and had a lump in the lower spine area. The doctor was unable to find a lump but said he would monitor her condition.

29. On 16 February 2014, the woman completed her methadone detoxification programme. On 28 February, a GP prescribed a laxative.

30. On 11 April, the woman told a nurse she had headaches and felt pressure in her head which was getting worse. The nurse referred her to the GP. A GP saw her on 15 April and prescribed mebeverine, to relieve stomach cramps, lansoprazole and paracetamol.

31. On 23 April, a nurse noted that the woman had a swollen stomach which got worse and more painful after eating. The nurse took a blood sample and referred her to the GP. The GP saw her the same day and recorded that the results from the blood test were normal.

32. At approximately 12.10pm on 27 April, an officer was carrying out a check to establish that all prisoners were present. A prisoner told her that the woman was too ill to attend and the officer went to her room and found her in bed. She said she had been sick and pointed to a bowl containing a black fluid. She said she was sweating but cold and her chest hurt. The officer did not consider the matter urgent and told her that once she had finished the roll check she would ask a nurse to come and see her.

33. At 12.20pm, the officer contacted the duty nurse. Two nurses went to see the woman immediately. They were there in less than a minute, as the house was near the healthcare centre.

34. The woman was still in bed and told one nurse that she had been unwell since the night before, but had not told anyone at the time. She said she had been sick and had chest pain. The nurse took her clinical observation and noted that she was short of breath; her oxygen saturation levels were low. Her colleague went back to the healthcare centre to get some oxygen while she stayed with the woman. As there was no improvement in her condition, at 12.25pm, she asked the control room to call an ambulance. Her colleague returned and administered oxygen.

35. The ambulance arrived at 12.34pm and the nurse gave the paramedics a verbal handover and a copy of the woman's medical record and prescriptions. At 1.20pm, the ambulance took her to hospital. Two officers escorted her and used handcuffs to restrain her.

36. The hospital admitted the woman and at 4.50pm a doctor asked the officers to remove the restraints. The officers obtained permission from a prison manager and removed them. The next day, the prison released her on temporary licence and left one officer with her for support. She stayed in hospital but her condition continued to deteriorate. She died a few days later.

Liaison with the woman's family

37. On 27 April, after the woman went to hospital, a custodial manager acted as the family liaison officer. At 5.45pm, she tried to contact the woman's sister, her nominated next of kin, but the numbers the prison had for her were incorrect. She rang the woman's sister-in-law and told her about her condition and that she was in hospital. She obtained a phone number for the woman's sister, but when she rang it there was no reply.

38. At 12.15pm on 28 April, the custodial manager went to the hospital and a nurse told her that the woman's sister and sister-in-law had both contacted the hospital that morning. She called the woman's sister but again there was no reply. The woman's son was in prison at HMP Wymott. At 2.30pm on 28 April, the custodial manager telephoned Wymott and arranged for him to visit his mother in hospital. He visited at 4.45pm that day.

39. The custodial manager had still been unable to speak to the woman's sister, although she had visited the woman in hospital. The prison had an address for her and planned to ask for an officer from a local prison to attend and notify her in the event of her sister's death.

40. On the morning of the woman's death, the duty governor informed the custodial manager. The custodial manager began making arrangements to contact the woman's sister. At 9.05am, a prison matron told her that the woman's sister had telephoned the prison earlier that morning as she had

heard that her sister had died. Her sister had left two additional contact telephone numbers, but she rang them both and again got no reply.

41. At 3.20pm, the custodial manager again tried to contact the woman's sister on the new numbers. There was no reply and she left a message. She eventually spoke to her on 30 April 2014 at 10.10am. She was upset that no one had contacted her sooner, but said that she understood the difficulties the custodial manager had experienced. The custodial manager stayed in contact with her from this point.

42. The funeral was on 21 May and the prison contributed toward the cost in line with national guidance.

Support for staff and prisoners

43. The Governor issued a notice announcing the woman's death, expressing his condolences and reminding prisoners of the support available. All prisoners subject to suicide and self-harm prevention procedures were monitored in case they had been adversely affected by the news of her death. A member of staff informed the women who lived in the woman's house personally and told them that they could speak to staff at any time or go to the chapel and speak to member of the chaplaincy team. Listeners (prisoners trained by the Samaritans to support other prisoner in distress) were available. The prison's care team supported staff who had been involved in her care.

Post-mortem

44. A post-mortem report concluded that on the balance of probabilities the woman died of sepsis due to bronchopneumonia and neutropaenia (a deficiency of white blood cells that fight infection) and that it was due to natural causes.

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ISSUES

Clinical Care

45. The clinical reviewer was not satisfied that the overall level of care the woman received at HMP Styal was equivalent to that which she might have expected to receive in the community. She has made a number of detailed recommendations for improving aspects of healthcare services at Styal. We have not repeated them all in this report, but the Head of Healthcare will need to address them.

46. In July 2007, five years before her prison sentence, the woman had been diagnosed with myotonic dystrophy. This is a progressive, degenerative muscle wasting condition, the symptoms of which also affect the heart, eyes, breathing, speech, swallowing and digestive tract. Respiratory and cardiac complications can be life threatening and careful management of treatment and medication is required.

47. The clinical reviewer found no evidence that the care plan agreed at the woman's initial reception assessment was followed up and there was no evidence of any proactive planning of her medical care. There was no record of multidisciplinary meetings between the agencies involved in her care or that they shared relevant documentation between them.

48. Records show that, during her time at Styal, the woman's mobility declined, yet no one referred her to the prison's physiotherapy service. The clinical reviewer noted that the decline in her mobility would have been an indication of deterioration in muscular dystrophy but there is nothing in the records to show that healthcare staff understood or acted on this.

49. Respiratory disease associated with myotonic dystrophy is regarded as life threatening and smoking and poor nutritional health exacerbate its progression. The clinical reviewer considered that deterioration in respiratory function contributed to the woman's death. She was concerned that there was nothing in the records to indicate that any member of healthcare staff was aware of this or that they made any effort to monitor her respiratory function. Failure to monitor respiratory function (using peak flows and spirometry) meant healthcare staff lost the opportunity to manage her care proactively and observe her for signs of deteriorating respiratory function. We make the following recommendation:

    The Head of Healthcare should ensure that prisoners with complex and chronic health conditions are actively monitored using a coordinated single case management plan, which is regularly reviewed and updated, and followed by staff.

50. There were a number of entries in the woman's clinical record indicating poor dietary intake and that she was very underweight. A care plan, agreed on 20 June 2012, with a nurse included weekly monitoring of her weight, but there is

no record that this happened. The records show she had a low body mass index (BMI), but they do not list what it was. The clinical reviewer noted that there is no evidence of the use of a validated screening tool (such as the Malnutrition Universal Screening Tool – MUST) which could have identified her as malnourished and required a referral to a dietician.

51. The National Institute for Health and Care Excellence (NICE) Quality Standard for Nutritional Support in Adults, recommends that any assessment should include screening for malnutrition using a validated tool. It is essential that screening is carried out for any prisoner who might be of risk of malnutrition to identify those in need of further investigation and subsequent nutritional support. This did not happen for the woman. We make the following recommendation:

The Head of Healthcare should ensure that an appropriate screening tool is used for all prisoners who might be at risk of malnutrition and that this is followed up with appropriate care plans when necessary.

Use of Restraints, security and escort

52. 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 account of 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.

53. On 27 April 2014, the woman went to hospital by emergency ambulance. Two officers escorted her and she was handcuffed to one of the officers. A nurse completed the medical section of the risk assessment and described her as short of breath, cyanosed and needing oxygen. However, she did not object to the use of restraints and did not consider that her medical condition restricted her ability to escape unaided. There was no mention of her restricted mobility. The security section of the assessment recorded that she presented a medium risk to the public and the risk of escape, hostage taking, and likelihood of outside assistance was low. On the basis of this information, an operational manager authorised that handcuffs should be used to restrain her.

54. Records show that the woman had previously left the prison unrestrained and unaccompanied a number of times. On 14 June 2013, she became eligible for release on temporary licence as part of her sentence progression and from that time she worked inside, and later outside, the prison grounds. She had attended numerous outpatient hospital appointments, accompanied but not restrained and from October 2013 she had been allowed overnight unaccompanied family visits.

55. On 23 March 2013, a senior manager stopped the woman's temporary release while the security unit investigated an allegation about her behaviour at work. The senior manager told the investigator this was not a factor when considering the use of restraints. She told us that, had she been fully aware of her circumstances, including her medical condition and the previous use of release on temporary licence, she would not have agreed the use of restraints and considered it unlikely that anyone would have done so. However, she did not have the information at the time.

56. A few hours after the hospital admitted her, the escorting officers obtained permission to remove the handcuffs, after a doctor had requested this. The next day, the prison released the woman on temporary licence and reduced the escort to one supporting officer. We are satisfied that that this was appropriate. While she was not restrained for long, we are concerned that the decision to authorise restraints was made on inadequate information.

57. There is need for all those involved in making decisions to ensure that they take a prisoner's health and mobility fully into account in risk assessments and that staff follow the guidance in the 2007 High Court judgment. Ultimately, it is the Governor's responsibility to ensure that the process is managed properly, but the Head of Healthcare also needs to ensure that healthcare staff understand their responsibilities when assessing how health and mobility impacts on the risk of escape. 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 and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that prisoners with complex and chronic health conditions are actively monitored using a coordinated single case management plan, which is regularly reviewed and updated, and followed by staff.

2. The Head of Healthcare should ensure that an appropriate screening tool is used for all prisoners who might be at risk of malnutrition and that this is followed up with appropriate care plans when necessary.

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

ACTION PLAN

No	Recommendation	Accepted/Not accepted	Response	Target date for completion and Function Responsible
1	The Head of Healthcare should ensure that prisoners with complex and chronic health conditions are actively monitored using a coordinated single case management plan, which is regularly reviewed and updated, and followed by staff.	Accepted	Since July 2014, all prisoners newly presenting with complex and chronic health conditions have been discussed at weekly multi-disciplinary clinical meetings, and clinical management and care planning is discussed and agreed. From 1 December 2014, all such discussions will be transferred to a single case management plan, with a nominated named nurse responsible for ensuring regular care plan update.	28 February 2015 Head of Healthcare / Healthcare Matrons
2	The Head of Healthcare should ensure that an appropriate screening tool is used for all prisoners who might be at risk of malnutrition and that this is followed up with appropriate care plans when necessary.	Accepted	In conjunction with the above recommendation, where a risk of malnutrition is identified the MUST (Malnutrition Universal Screening Tool) will be completed and regularly reviewed to inform care planning decisions. The MUST will be attached as an electronic template to SystmOne patient records.	28 February 2015 Head of Healthcare / Healthcare Matrons
3	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, and are based on the actual risk the prisoner presents at the time	Accepted	Risk assessments for prisoners taken to hospital will be based on a consideration of the individual's circumstances and the actual risk they present at the time. Assessments will be dynamic and the use of restraints will be reviewed, as necessary, to take into account any significant changes in circumstances. The Head of Healthcare and Security Governor will meet to discuss a joint approach to raising	28 February 2015 Head of Healthcare / Healthcare Matrons Head of Healthcare / Security Governor

			awareness. Awareness sessions for existing staff will be arranged. Information will be included in induction packs for all healthcare staff commencing employment from 1 March 2015.	