Prisons & Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Ms Christine Diskin a prisoner at HMP and YOI Styal on 25 December 2017

A report by the Prisons and Probation Ombudsman

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Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

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The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Ms Christine Diskin died in hospital on 25 December 2017 of heart failure and a leg infection while a prisoner at HMP Styal. She was 61 years old. I offer my condolences to Ms Diskin's family and friends.

Ms Diskin entered custody with a heart condition that caused fluid to build up inside her body. This caused a number of infections in her legs which resulted in hospital admissions where her health deteriorated further.

I am satisfied that Ms Diskin received a good standard of care at Styal, equivalent to the care she could have expected to receive in the community. However, I am concerned that she missed a hospital appointment due to prison transport arrangements. I also consider the use of restraints to have been excessive, failing to take sufficient account of her deteriorating condition.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

Elizabeth Moody
Acting Prisons and Probation Ombudsman **October 2018**

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Summary

Events

1. On 21 June 2017, Ms Christine Diskin was remanded to HMP Styal for drugs offences. She was diagnosed with high blood pressure and a heart condition that caused fluid to build up inside her body. She had a previous history of breast cancer. She had also been admitted to a psychiatric hospital a few months before being sent to prison.

2. In July, Ms Diskin struggled to manage in a three-person cell and was moved into a single cell so she could access the toilet more easily during the night. In August, she was admitted to hospital, diagnosed with an infection in her legs and was given medication to increase the passing of urine. Care plans were created to monitor her leg wounds and the fluid in her body.

3. On arrival at Styal, Ms Diskin had a first mental health assessment. In October, she was seen by a psychiatrist who requested a brain scan to check that her delusional beliefs were not caused by the spread of cancer to her brain. Ms Diskin did not have a scan until 14 December as her original appointment was missed because of prison transport issues. The results of her scan were normal.

4. On 25 November, Ms Diskin transferred to the Dove Unit to provide her with additional support as she was having trouble managing on her existing wing. During the move Ms Diskin sustained an injury to her leg. This incident was investigated appropriately by a prison manager.

5. Ms Diskin's condition became worse and she had a number of hospital admissions during November and December related to the infection in her legs and build-up of excess fluid in her body. When her diuretic medication was stopped the fluid build-up became problematic.

6. Ms Diskin was placed under restraint with single cuffs each time she was taken to hospital. On 23 December, she was taken to hospital as an emergency. The next day her restraints were removed and she died on 25 December.

Findings

7. We are satisfied that Ms Diskin received a good standard of care at Styal. However, we are concerned that she missed a hospital appointment unnecessarily and consider the use of restraints to be excessive.

Recommendations

- The Governor should ensure that appropriate arrangements are in place to make sure that prisoners are able to attend hospital appointments; and

- The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position on the use of restraints, 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.

The Investigation Process

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

9. The investigator obtained copies of relevant extracts from Ms Diskin's prison and medical records.

10. NHS England commissioned a clinical reviewer to review Ms Diskin's clinical care at the prison.

11. We informed HM Coroner for Cheshire of the investigation. He gave us the results of the post-mortem examination and we have sent the coroner a copy of this report.

12. The investigator wrote to Ms Diskin's son to explain the investigation and to ask whether he had any matters he wanted the investigation to consider. He did not respond to our letter.

Background Information

HMP Styal

13. HMP Styal is a prison in Wilmslow, Cheshire holding up to 460 women. There is 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. The Dove Unit is a specialist unit for women, offering therapeutic support to women with complex needs.

14. Spectrum Community Health runs healthcare services at the prison. Lifeline delivers psychosocial intervention to substance users. Greater Manchester West Mental Health NHS Foundation Trust provides mental health services. There are nurses on duty at all times, with a registered nurse and a health support worker available at night. GP sessions are held every day except Sundays, when there is an out of hours service. There is no in-patient facility.

HM Inspectorate of Prisons

15. The most recent inspection of HMP Styal was conducted in November 2014. Inspectors reported that Styal was a very good prison and they were impressed with efforts to give prisoners responsibility for themselves. They noted that most prisoners felt safe and there were good relationships between staff and prisoners. They found there was no prison-based safeguarding policy and a better coordinated prison approach to this was needed. They found that most women were dissatisfied with healthcare services but access to primary services was good.

Independent Monitoring Board

16. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to April 2017, the IMB reported that women are generally satisfied with the healthcare services provided but the constant changes in healthcare staff impact on the services offered and make it difficult for the team to address any concerns.

Previous deaths at HMP Styal

17. Ms Diskin was the first prisoner to die of natural causes since June 2014.

Key Events

18. On 21 June 2017, Ms Christine Diskin was remanded to HMP Styal for drugs offences. She had been in prison 20 years earlier. Ms Diskin had a history of drug misuse. She also had a history of breast cancer. In 2016, she was diagnosed with high blood pressure and congestive heart failure (meaning the heart is unable to pump efficiently) causing a build-up of fluid in the body. During March and April 2017, Ms Diskin was admitted to a psychiatric hospital and diagnosed with schizophrenia.

19. Ms Diskin received a healthcare assessment on arrival at Styal and her regular medications, including methadone (a heroin substitute), were prescribed. On 22 June, a mental health nurse met with Ms Diskin to complete a mental health screening. Ms Diskin said that she heard voices and said that someone had inserted plastic into her leg and neck, which was causing her to retain water. The nurse planned to obtain the records from Ms Diskin's psychiatric hospital admission and arrange for a mental health assessment to take place. Ms Diskin did not attend a mental health assessment appointment on 4 July.

20. On 4 July, Ms Diskin was moved from a three-person cell to a single cell with a toilet because she had difficulty getting to the toilet in the larger cell during the night. Wing staff made a referral for her to see a doctor. On 8 July, Ms Diskin began taking antibiotics for cellulitis (a skin infection) of her left leg. A prison GP reviewed Ms Diskin on 10 July and requested that a chest X-ray and a doppler procedure (to determine whether the blood flow in her legs was satisfactory) were completed. A chest X-ray showed up an infection, which was treated with antibiotics.

21. On 5 August, Ms Diskin told a prison GP that her feet felt numb. He could not find a pulse in her foot, which was cold and tender. The GP thought she might also have a chest infection. Ms Diskin went to hospital for an assessment. Information on whether restraints were used was not made available to the investigator. Ms Diskin returned the next day, diagnosed with cellulitis, and was prescribed antibiotics and increased diuretics. (These are drugs intended to increase the passing of urine.)

22. Ms Diskin's leg infections were reviewed regularly and a care plan was created. Her weight was recorded weekly to assess the amount of fluid in her body.

23. On 21 August, Ms Diskin asked to begin methadone reduction treatment which continued over September and October. On 10 October, a nurse was concerned that Ms Diskin's mental health was deteriorating as she could not remember why her methadone was reduced. Her methadone was increased slightly to stabilise her, and the nurse spoke with a mental health worker about her presentation.

24. On 11 October, a mental health nurse met with Ms Diskin and reported that she engaged well in the session. On 13 October, a psychiatrist reviewed Ms Diskin and considered that an urgent oncology appointment was required. This was to establish whether a brain scan could rule out the spread of cancer to her brain as a possible explanation for Ms Diskin's delusional beliefs. He noted that a blood test had revealed a raised marker for breast cancer. On 18 October, an MRI scan was requested but did not take place until 14 December. (An appointment

arranged for 30 November was missed due to prison transport issues.) The results of the scan were normal.

25. On 21 November, at 2.30am, a nurse attended Ms Diskin's cell because she was complaining of chest pain. The nurse was concerned that Ms Diskin's cell was very unkempt. Ms Diskin was upset and tearful and said that she was urinating in a plastic cup and each time she stood up urine ran out. The nurse planned to tell officers about the cell and gave Ms Diskin paracetamol for her pain. Ms Diskin was monitored during the day and sent to hospital for assessment. She was escorted by two officers and kept under restraint with single cuffs. She returned from hospital the same day with no further treatment required.

26. On 23 November, Ms Diskin was taken to hospital as prison doctors were concerned about her jaundice. They also noted blood test results indicated the possible return of her cancer and considered she might have a possible diagnosis of a malignancy. She was escorted by two officers and again restrained with single cuffs. Ms Diskin returned from hospital on 24 November with a diagnosis of dehydration, and her diuretic medication was stopped.

27. On 25 November, Ms Diskin transferred to the Dove Unit because she was struggling to manage on her wing. A wheelchair was brought to her cell and because she refused to get into the wheelchair officers lifted her into it and took her to the unit. The duty governor and nurses were present. On arrival, Ms Diskin refused to get out of the wheelchair. Officers recorded that when they tried to lift her out of the wheelchair, she deliberately slumped to the floor, refused to get on the bed and shouted at them to get out of her cell. They left Ms Diskin on the floor. Ms Diskin was later found to have sustained a skin tear to her lower leg during the move. On 6 December, Ms Diskin told a mental health nurse that her injury was due to an officer tipping her out of her wheelchair. The nurse reported this concern to the Head of Safer Custody and an internal investigation into the incident took place

28. On 27 November, wing staff said that Ms Diskin was struggling to mobilise and that she told them she could not get her medication because she was in pain. A physiotherapist was unable to assess her mobility because Ms Diskin refused to walk because she was in pain. The physiotherapist noted the wound on her leg.

29. Ms Diskin's leg was monitored daily by healthcare staff, both as part of the pre-existing care plan and because of the wound sustained on 25 November. It was dressed appropriately. On 3 December, staff noticed Ms Diskin walking around the unit with saturated toilet paper wrapped around her leg. Her dressings were changed as a result.

30. On 5 December, a prison GP reviewed Ms Diskin and noted that she was gaining weight and fluid was building up in her legs since her diuretic medication had been stopped. On 8 December, Ms Diskin was taken to hospital because she had swelling in both legs and thighs, and said she had a tightness in her chest. She was escorted by two officers and single cuffs were applied. She was given intravenous diuretic medication to relieve the excess fluid in her body. She returned from hospital the next day because she had responded well to treatment.

31. On 11 December, a nurse found Ms Diskin wrapped in a blanket because she had no dry clothes or clothes that fitted. She had been incontinent and her leg dressing was unfolding. The nurse referred Ms Diskin for a GP appointment and requested some new clothes for her. A prison GP saw Ms Diskin the same day and said that a multidisciplinary meeting was required to put in place a long-term care plan for Ms Diskin in view of her deteriorating heart function.

32. On 12 December, Ms Diskin appeared disorientated during the night and was checked every two hours because of this. She was taken to hospital later that day due to abnormal blood test results. The Escort Risk Assessment details were not made available to the investigator for this transfer. Healthcare staff kept in regular contact with the hospital about Ms Diskin's condition. She remained in hospital until 22 December.

33. On 14 December, a multidisciplinary meeting took place to discuss Ms Diskin's care. She had given permission for her son to be contacted. Concern was raised over how long Ms Diskin had left to live and whether compassionate release could be considered.

34. On 22 December, a prison GP and a nurse reviewed Ms Diskin on her return to prison. Extra pillows were requested to help her to sit upright and an appropriate mattress to help relieve her pressure areas. She also required appropriate footwear to help her to mobilise. The nurse put in place a care plan for Ms Diskin.

35. On 23 December, at 2.10am, a nurse attended Ms Diskin's cell at the request of an officer. Ms Diskin was struggling to catch her breath, her oxygen levels were low and her heart rate was very fast. An emergency ambulance was called and Ms Diskin was taken to hospital. She was escorted by two officers and restrained with single cuffs. The hospital confirmed that Ms Diskin would remain in hospital for two or three days for intravenous diuretic treatment and that she had significant swelling to her legs.

36. On 24 December, Ms Diskin's restraints were removed. On 25 December, the hospital asked for her next of kin details and told escort staff that she had sepsis from her leg wound to her hip, and her condition was deteriorating. Ms Diskin began intravenous pain relief and died at 6.55am.

Contact with Ms Diskin's family

37. On 15 December 2017, an operational manager attended a meeting with healthcare staff to discuss Ms Diskin's care and took up the role of family liaison officer (FLO). Later that day she went to the address listed for Ms Diskin's son to inform him that she was unwell in hospital. He was not in and so she left a note with her details.

38. Ms Diskin's son was located at HMP Forest Bank when she died. On 27 December, prison staff visited him there to inform him of her death. The FLO visited him a few days later to discuss funeral arrangements, return of property and check on his well-being. The funeral took place on 1 February 2018 and the prison contributed to funeral costs in line with national policy.

Support for prisoners and staff

39. After Ms Diskin's death, a prison manager debriefed the escort staff who were present when Ms Diskin died, to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

40. The prison posted notices informing other prisoners of Ms Diskin's death, and offered support.

Post-mortem report

41. The results of the post mortem investigation indicated that the causes of Ms Diskin's death were cardiac failure, dilated cardiomyopathy (a decrease in the heart's ability to pump blood), chronic drug abuse, cellulitis of left leg and pulmonary embolism. The toxicology report results were normal.

Findings

Clinical care

42. Ms Diskin entered custody with chronic health conditions and a history of mental health problems. We agree with the clinical reviewer that the care provided to Ms Diskin at HMP Styal was equivalent to that which she could have expected to receive in the community.

43. The clinical reviewer makes six recommendations which the Head of Healthcare will want to consider.

Missed hospital appointment

44. On 30 November 2017, Ms Diskin was due to attend a hospital appointment for a MRI brain scan. She did not attend this appointment because a first taxi arranged by the prison was missed and a second taxi would not get there in time for the appointment. Her scan was rearranged for 14 December. Although the results of this scan were normal it is important that prisoners can attend their hospital appointments. We make the following recommendation:

    The Governor should ensure that appropriate arrangements are in place to make sure that prisoners are able to attend hospital appointments.

Safeguarding concern

45. On 25 November 2017, the duty governor decided to relocate Ms Diskin from her wing to the Dove Unit as she required extra support. A wheelchair was brought to assist the move but because Ms Diskin refused to get into the wheelchair, officers lifted her into it. She was taken to the Dove Unit but refused to get out of the wheelchair on arrival so officers lifted her out of the chair and tried to lift her onto the bed. Ms Diskin slumped onto the floor and during this process she sustained an injury to her leg.

46. On 6 December 2017, Ms Diskin told a nurse that an officer had thrown her onto the floor and injured her leg. The nurse sent an email to the Head of Safer Custody to inform her of this allegation.

47. On 15 February 2018, an operational manager completed an inquiry into the incident. She interviewed staff involved and reviewed the 'use of force' paperwork that had been completed. She concluded that the injury that Ms Diskin sustained was not due to any inappropriate action by staff. We are satisfied that the prison investigated this incident appropriately.

Use of restraints

48. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital. It also has a responsibility to balance this by treating prisoners with humanity. 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 takes into account the prisoner's health and mobility. A judgment in the High Court in 2007, made it clear that prison staff need to distinguish between the prisoner's risk of escape

when fit (and the risk to the public in the event of an escape) and the prisoner's risk when suffering from a serious medical condition. The judgment indicated that prison staff must take into account medical opinion about the prisoner's ability to escape and keep this under review as circumstances change.

49. Ms Diskin had several hospital appointments. The prison could not provide escort risk assessments for all the appointments. However, where the risk assessments were provided, Ms Diskin was assessed on each occasion as a low risk of escape and low risk of harm to others. There were no medical objections to the use of restraints but there was no medical information provided to document Ms Diskin's increasing lack of mobility.

50. For each appointment, she was restrained with single cuffs which were removed the day before she died. We consider the use of restraints inappropriate as the risk assessments did not fully consider Ms Diskin's state of health. 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 on the use of restraints, 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.

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