

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Ms Stacey Berrisford a prisoner at HMP Styal on 3 April 2020

A report by the Prisons and Probation Ombudsman

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*



© Crown copyright 2021

This report is licensed under the terms of the Open Government Licence v3.0. To view this licence, visit nationalarchives.gov.uk/doc/open-government-licence/version/3 or email the Copyright Team at psi@nationalarchives.gov.uk

Where we have identified any third-party copyright information you will need to obtain permission from the copyright holders concerned.

When you use this information under the Open Government Licence, you should include the following attribution: Independent investigation into the death of Ms Stacey Berrisford, a prisoner at HMP Styal, on 3 April 2020, Prisons and Probation Ombudsman, December 2020, licensed under the Open Government Licence.

Summary

1. 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.
2. We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.
3. Ms Stacey Berrisford died in The Christie Hospital, Manchester on 3 April 2020 of skin cancer while a prisoner at HMP Styal. She was 34 years old. I offer my condolences to Ms Berrisford's family and friends.
4. The clinical reviewer concluded that the clinical care Ms Berrisford received at Styal was equivalent to that she could have expected to receive in the community. She made no recommendations.
5. We found no non-clinical issues of concern. We make no recommendations.

The Investigation Process

6. NHS England commissioned an independent clinical reviewer to review Ms Berrisford's clinical care at Styal.
7. The PPO investigator has investigated non-clinical issues, including Ms Berrisford's location, the security arrangements for her hospital escort, liaison with her family and whether compassionate release was considered.
8. The PPO family liaison officer wrote to Ms Berrisford's next of kin, her father and grandmother, to explain the investigation. They did not have any specific questions for us to consider. They also received a copy of the initial report. They did not make any comments.
9. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Previous deaths at HMP Styal

10. Ms Berrisford was the fourth prisoner to die at Styal since April 2018. Of these deaths, three were self-inflicted. There has been one death since which is currently under investigation. There are no similarities between our findings in the investigation into Ms Berrisford's death and our investigation findings for the previous deaths.

Key Events

11. Ms Stacey Berrisford was sentenced to one month and 25 days for taking a child from a responsible person and sent to HMP Styal on 12 March 2020.
12. A prison GP completed Ms Berrisford's initial health assessment with a female nurse as chaperone. Ms Berrisford had a recent history of abdominal pain and had been due for a computerised tomography scan (CT – a detailed scan of the inside of the body) in hospital that day. On examination, the prison GP became concerned that Ms Berrisford had a bleed in her gastro-intestinal tract area with an underlying malignancy (bleeding connected to a tumour). He arranged for her to go to hospital, but Ms Berrisford discharged herself because she did not want to be admitted due to the COVID-19 crisis. She returned to Styal.
13. The prison GP reviewed Ms Berrisford the next morning, 13 March. He was also concerned about her symptoms and stressed the risks of her refusing to go to hospital. The prison GP referred Ms Berrisford for an urgent endoscopy (an internal examination using a camera). On 14 March, prison nurses persuaded Ms Berrisford to go to hospital for further investigation.
14. Ms Berrisford was diagnosed with melanoma (a type of skin cancer) that had spread to multiple organs in her body.
15. Release on temporary licence (ROTL) can be granted for precisely defined and specific activities which cannot be provided in the prison. A risk assessment is completed to ensure that the prisoner's temporary release does not present unacceptable risks. The Governor of the prison is able to grant the temporary licence and will decide on whether the prisoner is to be accompanied by staff. On 23 March, the Governor granted Ms Berrisford temporary release to go to hospital, accompanied by one member of staff.
16. She remained in hospital and received palliative care. On 27 March, Ms Berrisford said she did not want anyone to resuscitate her if her heart or breathing stopped and signed an order to that effect.
17. On 31 March, an application for Ms Berrisford's early release on compassionate grounds was submitted to the Public Protection Casework Section (PPCS) of Her Majesty's Prison and Probation Service (HMPPS). Ms Berrisford died before a decision was made on the application.
18. Ms Berrisford was transferred to The Christie Hospital on 1 April and she died there on 3 April 2020.
19. The Coroner confirmed the cause of death as metastatic melanoma and no post-mortem examination was carried out.

Sue McAllister CB
Prisons and Probation Ombudsman

December 2020

**Prisons &
Probation**

Ombudsman
Independent Investigations