Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Ms Shareen Akhtar a prisoner at HMP Styal on 16 April 2020

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*

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 Shareen Akhtar died of heart and respiratory failure at HMP Styal on 16 April 2020. She was 41 years old. We offer our condolences to Ms Akhtar's family and friends.

4. The clinical reviewer concluded that the clinical care Ms Akhtar received at Styal was equivalent to that she could have expected to receive in the community.

5. We found that the staff member who found Ms Akhtar unconscious did not radio a medical emergency code as he should have done. Although this caused a minimal delay in healthcare staff attending and in an ambulance being called, staff need to be reminded to follow the correct procedures in a medical emergency.

Recommendations

- The Governor should ensure that staff are aware of and understand their responsibilities during medical emergencies, including the use of the correct medical emergency code.

The Investigation Process

6. NHS England commissioned an independent clinical reviewer to review Ms Akhtar's clinical care at Styal.

7. The PPO investigator has investigated non-clinical issues, including Ms Akhtar's location, the security arrangements for her hospital escorts, liaison with her family and whether compassionate release was considered.

8. One of the PPO's family liaison officers wrote to Ms Akhtar's next of kin, her husband, to explain the investigation. He did not respond.

9. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies and their action plan is annexed to this report.

Previous deaths at HMP Styal

10. Ms Akhtar was the fifth prisoner to die at Styal since April 2018. Of the previous deaths, one was from natural causes and three were self-inflicted. We have previously made recommendations to Styal about the use of medical emergency codes.

Key Events

11. On 5 November 2019, Ms Shareen Akhtar was sentenced to three years in prison for fraud. On 26 November, she was moved to HMP Styal.

12. Ms Akhtar had complex health needs resulting from several serious long-term conditions including chronic respiratory failure, pulmonary hypertension (high blood pressure in the vessels that supply the lungs), left and right ventricular failure (where the heart muscle fails to pump blood properly), tricuspid regurgitation (faulty heart valve) and kyphoscoliosis (a congenital deformity of the spine). She took a significant amount of medication for her various conditions and needed access to oxygen 24 hours a day. At night she wore a mask attached to a Continuous Positive Airway Pressure machine (CPAP) that delivered constant and steady air pressure.

13. Ms Akhtar was located in a disability cell. She had health and social care plans in place. Her life expectancy was assessed as six to eight years with good adherence to non-invasive ventilation (CPAP), reducing to two to three years with poor adherence. She attended several outside hospital appointments for which she was released on temporary licence (ROTL), accompanied by one officer for support.

14. On 27 March 2020, the prison submitted an application for Ms Akhtar's early release on compassionate grounds to the Public Protection Casework Section (PPCS) of Her Majesty's Prison and Probation Service (HMPPS). The application was refused on the grounds that Ms Akhtar's condition was stable with a life expectancy of two to three years.

15. On 6 April, following the outbreak of COVID-19, the prison considered applying for compassionate temporary release for Ms Akhtar, but she did not meet the criteria at that time. On 16 April, the prison applied for compassionate temporary release for Ms Akhtar, but she died before it was considered.

16. On 16 April, at 10.15pm, an Operational Support Grade (OSG) discovered Ms Akhtar unconscious on the floor of her cell with her oxygen mask by her side. The OSG could not find a pulse and radioed for assistance and for an ambulance to be called. He began cardiopulmonary resuscitation (CPR) and was joined almost immediately by other officers and healthcare staff. The ambulance arrived at the prison in under seven minutes. Ambulance paramedics continued resuscitation attempts but at 10.52pm, they declared that Ms Akhtar had died.

Post-mortem report

17. The post-mortem report concluded that Ms Akhtar died from biventricular and hypercapnic cardiorespiratory failure (failure of both sides of the heart with high levels of carbon dioxide in the blood) caused by spondylocostal dysostosis (a rare skeletal growth disorder) with morbid obesity.

Non-Clinical Findings

Emergency Response

18. Prison Service Instruction 03/2013, *Medical Emergency Response Codes*, requires Governors to have a two-code medical emergency response system. HMP Styal use code blue to indicate an emergency when a prisoner is unconscious or having breathing difficulties, and code red when a prisoner is bleeding. Calling an emergency code alerts the control room to call an ambulance immediately. It also gives healthcare staff an indication about the incident that they are attending and about the equipment they are likely to need.

19. The OSG did not use a medical emergency code when he found Ms Akhtar unconscious. We accept that the OSG promptly radioed for assistance and asked the control room to call an ambulance, so any delays were minimal. However, it is important that staff follow the correct procedures when dealing with a medical emergency, so that all staff are clear on the type of situation they are dealing with and the action required. We recommend:

The Governor should ensure that staff are aware of and understand their responsibilities during medical emergencies, including the use of the correct medical emergency code.

Louise Richards
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