Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Ms Annelise Sanderson, a prisoner at HMP & YOI Styal, on 22 December 2020

A report by the Prisons and Probation Ombudsman

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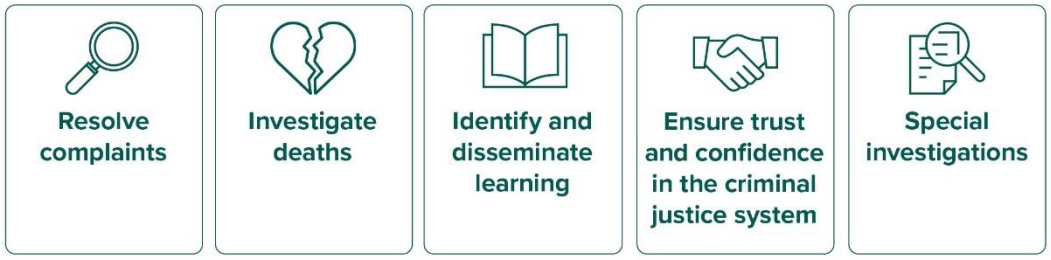
OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO



WHAT WE VALUE

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 Annelise Sanderson died on 22 December 2020 having been found hanged in her cell at HMP & YOI Styal. She was 18 years old. I offer my condolences to Ms Sanderson's family and friends.

Our investigation found that Ms Sanderson hid the full extent of her distress from staff, and I am satisfied that they had no reason to consider that she was at risk of suicide or self-harm at the time of her death.

However, Ms Sanderson did have some risk factors and was subject to suicide and self-harm prevention procedures (known as ACCT) for nine days shortly after she arrived at Styal. I have some concerns about how these procedures were managed and how her risk was assessed. In addition, while I fully appreciate the difficulties of maintaining meaningful contact with prisoners during the COVID-19 pandemic, I consider that more should have been done to engage with Ms Sanderson in the months before her death.

Ms Sanderson received appropriate support from the mental health and substance misuse teams. However, I am concerned that staff did not use an emergency code when they found Ms Sanderson unresponsive, and also that they attempted to resuscitate her despite it being apparent that she had been dead for some time. I have previously made recommendations to Styal about both these issues.

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

Sue McAllister, CB
Prisons and Probation Ombudsman **June 2022**

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Summary

Events

1. On 26 June 2020, Ms Annelise Sanderson was sentenced to 52 weeks imprisonment for assault and theft and taken to HMP and YOI Styal. Her behaviour over the next few days was volatile, bizarre and threatening to staff and prisoners. Mental health and substance misuse staff assessed Ms Sanderson and she completed an alcohol detox.

2. Between 29 June and 7 July, Ms Sanderson was subject to suicide and self-harm prevention procedures (known as ACCT) due to her low mood and withdrawal from alcohol. After this point she was not considered a risk to herself. Over the following weeks, Ms Sanderson became more settled, and her behaviour improved.

3. Ms Sanderson was regularly reviewed by the mental health team and from 9 September was prescribed antidepressants. On 11 December, Ms Sanderson was sentenced to a further 12 weeks' imprisonment and her new release date was 21 January 2021.

4. On 22 December around 5.50am, staff found Ms Sanderson hanging from her bunk bed. They cut her down and tried to resuscitate her despite signs of rigor mortis. The paramedics arrived and asked staff to stop resuscitation attempts. At 6.13am, the paramedics pronounced that Ms Sanderson had died.

5. After Ms Sanderson died, police found notes which were suspected to have been written by her indicating that she thought she would be better off dead. Prisoners told a nurse that she had been in a relationship with her roommate, and they had had an argument the night before she died.

Findings

6. Ms Sanderson was managed under ACCT procedures from 29 June to 7 July 2020. We are concerned that an ACCT was not opened sooner when Ms Sanderson arrived at Styal given her risk factors. We also have some concerns about how the ACCT was managed and how Ms Sanderson was cared for during that time.

7. However, we are satisfied that there was no reason for Ms Sanderson to have been managed under ACCT procedures at the time of her death and we do not consider that staff could have been expected to predict or prevent Ms Sanderson's actions the night she died. A few days before Ms Sanderson's death, her partner in the community was sectioned under the Mental Health Act and told Ms Sanderson that she had tried to hang herself. Ms Sanderson did not share this distressing information with staff.

8. The clinical reviewer concluded that Ms Sanderson's physical, mental health and substance misuse care were of a good standard and equivalent to that she could have received in the community.

9. We are concerned that there were no structured, regular welfare checks on Ms Sanderson after the ACCT was closed, but only brief welfare checks with different members of staff which did little to identify how Ms Sanderson was feeling.

10. We are concerned that no emergency code was radioed when Ms Sanderson was found hanging. This meant that healthcare staff did not bring a defibrillator to the scene and caused a delay in requesting an ambulance. Although it did not affect the outcome for Ms Sanderson, as she had been dead for some time when she was found, it could make a critical difference in other medical emergencies.

11. We are also concerned that prison and healthcare staff attempted to resuscitate Ms Sanderson despite there being clear signs of rigor mortis. We have drawn both these matters to the attention of the Governor in previous investigations.

Recommendations

- The Governor and Head of Healthcare should ensure that staff manage prisoners at risk of suicide or self-harm in line with national guidelines and all known risk factors are considered when identifying and managing the level of risk of suicide and self-harm.
- The Governor should ensure that the key worker scheme is properly embedded and that key workers are allocated sufficient time for an average of 45 minutes per prisoner per week for delivery of the key worker role.
- The Governor should ensure that all prison staff are made aware of and understand their responsibilities during medical emergencies, in particular that staff efficiently communicate the nature of a medical emergency using the appropriate code.
- The Governor and Head of Healthcare should ensure that staff are given clear guidance and check their understanding about the circumstances in which resuscitation is inappropriate in accordance with European Resuscitation Council Guidelines.

The Investigation Process

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

2. Due to the COVID-19 pandemic, the investigator was unable to visit the prison or listen to Ms Sanderson's last telephone calls. He obtained copies of relevant extracts from Ms Sanderson's prison and medical records via post and email.

3. The investigator interviewed 15 members of staff. He was unable to interview Ms Sanderson's cellmate, as she was released two days after Ms Sanderson died. We have removed Ms Sanderson's cellmate's name from this report in order to safeguard her identity.

4. NHS England commissioned a clinical reviewer to review Ms Sanderson's clinical care at the prison. The investigator and clinical reviewer jointly interviewed healthcare staff. All the interviews were conducted by video-link because of the COVID-19 restrictions.

5. We informed HM Coroner for Cheshire of the investigation. The post-mortem report was not available at the time of issuing this report, but the pathologist provided a preliminary cause of death. We have sent the coroner a copy of this report.

6. One of the Ombudsman's family liaison officers contacted Ms Sanderson's mother to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She asked:

   - Why was Ms Sanderson allowed to have a flag when it was known she was suicidal?
   - Why did Ms Sanderson's cellmate not alert anyone when she hanged herself?
   - How often was Ms Sanderson supposed to be checked and how often was she actually checked? When was she last checked?
   - Ms Sanderson told her mother she was stockpiling her sertraline medication. Her mother informed the prison. Did the prison act on this information?

7. Ms Sanderson's family received a copy of the draft report. The solicitor representing them wrote to us raising a number of questions that do not impact on the factual accuracy of this report. We have provided clarification by way of separate correspondence to the solicitor.

12. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out a factual inaccuracy and this report has been amended accordingly.

Background Information

HMP & YOI Styal

13. HMP Styal holds up to 486 women. There is a variety of residential units, with 16 separate houses each holding about 20 women, and a mother and baby unit.

14. Spectrum Community Health runs healthcare services at the prison. Greater Manchester West Mental Health NHS Foundation Trust provides mental health services. There are always nurses on duty with one 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 in May 2018. Inspectors reported that women were well cared for when they arrived at Styal and induction was thorough. They found that the management of prisoners on ACCTs was good. The availability of illicit substances was high and over 50% of women said they had a drug problem on arrival. Inspectors found that new arrivals with substance misuse issues were promptly identified, received appropriate medication and were referred for psychosocial support.

16. Inspectors noted that most staff interactions with prisoners they observed were good and respectful and some were excellent. Healthcare was reasonably good, with a good range of primary care services and mental health interventions.

Independent Monitoring Board

8. 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 annual report, for the year to 30 April 2020, the IMB reported that the new Governor identified the safety of prisoners and the security of the regime as key priorities. Consequently, there had been significant changes which had positively affected safety. The IMB also found that prisoners were well supported on a one-to-one basis by the mental health team. They reported that relationships between staff and prisoners were generally positive.

Previous deaths at HMP & YOI Styal

17. Ms Sanderson is the fifth prisoner to die at Styal since December 2018. Two of these previous deaths were self-inflicted and two were due to natural causes. Our investigations into these deaths have resulted in recommendations that staff use the correct emergency medical code, and they are aware when it is not appropriate to try to resuscitate a prisoner. We have also previously made a recommendation about ACCT and risk management.

Assessment, Care in Custody and Teamwork

18. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner.

19. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular, multi-disciplinary review meetings involving the prisoner. As part of the process, a caremap (a plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the caremap have been completed.

20. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody)*.

Key Events

21. From July 2019 to February 2020, Ms Annelise Sanderson was detained in Rainsbrook Secure Training Centre. Medical records from this time indicate she had previously taken three serious overdoses and had tied a ligature (potential noose) in 2010.

22. On 26 June 2020, aged 18, Ms Sanderson was sentenced to 52 weeks imprisonment for assault and theft. She was taken to HMP & YOI Styal. On arrival, she was abusive to staff and threw water at the Governor. The mental health team leader tried to assess Ms Sanderson, but she did not engage with her and acted bizarrely. Another nurse tried to complete her initial healthscreen, but this was also difficult due to Ms Sanderson's behaviour. Ms Sanderson said that she had tried to take her own life in the last twelve months.

23. Court staff telephoned the mental health team and told them that Ms Sanderson had a history of self-harm and had recently covered herself in petrol. Healthcare staff also spoke to the local authority who said that Ms Sanderson had been under the influence of alcohol on 23 June and had poured petrol on herself and tried to drink petrol. Paramedics had tried to assist her, and she had assaulted them and then the police when they arrived. Ms Sanderson had been in police custody from that time until she appeared at court. They said that Ms Sanderson had no mental health diagnosis but misused alcohol.

24. On 27 June, a nurse assessed Ms Sanderson's mental health. Ms Sanderson said that she was a risk to others as she was feeling mentally unwell. She said she had suffered from depression since the age of 13 and had a history of self-harm. Ms Sanderson said she had no current thoughts of suicide or self-harm. Healthcare staff from the substance misuse team also assessed Ms Sanderson and prescribed her chlordiazepoxide (used to help with the symptoms of alcohol withdrawal). They monitored her withdrawal symptoms over the following days.

25. That evening, staff noted in Ms Sanderson's record that there were potential ligatures hanging out of her cell and she said she was being sick. Staff informed a manager and healthcare staff. She later set fire to her wardrobe. There is no evidence that staff considered starting Prison Service suicide and self-harm prevention measures (known as ACCT). On 28 June, Ms Sanderson was more settled, although still demonstrating some bizarre behaviour and thoughts. She telephoned her mother.

26. On 29 June, a nurse started ACCT monitoring due to Ms Sanderson's low mood and alcohol withdrawal. Ms Sanderson was observed hourly with two conversations a day. Staff recorded that she was awake all night and continued to act strangely.

27. On 30 June, Ms Sanderson told staff, during her ACCT assessment, that she wanted to die. The mental health team leader and an offender manager held an ACCT case review with Ms Sanderson. They noted that she did not seem to know where she was. Ms Sanderson had torn her bedsheet and made a loose ligature around her neck. The offender manager asked her about it, and she said it stopped her from strangling herself and made her feel happier. The offender manager let

her keep the ligature around her neck as she judged it would have caused her more distress to remove it. One action was noted on Ms Sanderson's caremap for her to complete her alcohol detox.

28. On 2 July, Ms Sanderson told staff she had swallowed a battery. Healthcare staff tried to examine her, but she did not comply. On 7 July, the mental health team leader and an offender manager held an ACCT review with Ms Sanderson. They closed the ACCT as she was being seen by the mental health team and had completed her detox, the only action on her caremap.

29. On 8 July, an offender manager noted on Ms Sanderson's record that she said she had not spoken to her mother since arriving at Styal. The offender manager telephoned Ms Sanderson's mother, who said that she had spoken to Ms Sanderson on 7 and 8 July. Ms Sanderson's mother said she was worried about her daughter because she said that she had swallowed a couple of batteries. She was concerned her daughter would try to take an overdose of paracetamol, which she was not allowed due to liver damage from a previous overdose three years ago. She also said she was stockpiling medication. The offender manager passed this information to a supervising officer (SO) who informed the wing nurses. Healthcare staff confirmed that Ms Sanderson was not prescribed paracetamol. They discussed whether to reopen the ACCT but decided not to as no one was certain that she had swallowed a battery. Staff also submitted an intelligence report.

30. On 9 July and 12 July, Ms Sanderson assaulted two different officers. On both occasions, prison staff used control and restraint techniques to control Ms Sanderson and return her to her room. On 10 July, an officer checked Ms Sanderson's welfare and noted no concerns.

31. On 13 July, an officer saw Ms Sanderson for a safer custody welfare check, as she had been restrained by staff the day before. Ms Sanderson said that she was okay and had no injuries. The officer noted that Ms Sanderson refused to take any responsibility for the situation and showed no remorse for her violence towards staff. Later that day, another officer also checked her welfare.

32. On 20 July, an offender manager completed an ACCT post-closure review with Ms Sanderson. She raised no concerns and said she had the support of her mother and sister. On 26 July, an officer did a welfare check with Ms Sanderson and noted that her engagement with staff had improved although she still demonstrated some odd behaviour.

33. On 27 July, an officer picked up a voicemail message from the safer custody telephone from Ms Sanderson's mother. She was concerned about Ms Sanderson's welfare. The officer telephoned Ms Sanderson's mother several times but could not get through. The officer spoke to a manager about it and visited Ms Sanderson, but she refused to talk about it. The officer noted that she was not visibly distressed, and he could not see any signs of self-harm.

34. On 5 August, Ms Sanderson asked if she could be prescribed a mood stabiliser and this information was passed to the mental health team leader. On 12 August, the mental health team leader and a nurse reviewed Ms Sanderson. She said that she wanted to change her life and manage her mood. Ms Sanderson agreed to discuss a sertraline (antidepressant) prescription with a prison GP.

35. The same day, an officer checked Ms Sanderson's welfare and recorded that she said that she had no concerns. An offender supervisor also introduced herself to Ms Sanderson. They discussed her possible release and suitable addresses. Ms Sanderson said she felt "okay".

36. On 14 August, a nurse from the substance misuse team reviewed Ms Sanderson. Ms Sanderson denied taking any illicit substances and said that she had considered reducing her alcohol intake in the community. Ms Sanderson also said that she had no thoughts of suicide or self-harm. The nurse explained the risks from illicit substances and planned to see Ms Sanderson in six weeks.

37. On 23 August, an officer did a welfare check on Ms Sanderson and noted that she seemed to be progressing on the wing. Ms Sanderson said that she felt "good". An officer completed further welfare checks on 5 September and 19 September when Ms Sanderson also raised no concerns.

38. On 8 September, a multidisciplinary team meeting discussed Ms Sanderson and decided that a prison GP should prescribe her sertraline to stabilise her mood. She was prescribed the medication the next day and had to pick it up daily. The first time she collected it was 17 September as she said she did not know it had been prescribed. Ms Sanderson also regularly attended Stepping Stones, a group run by the prison's safer custody team to increase prisoners' confidence, including using mindfulness and yoga.

39. On 25 September, a nurse and the mental health team leader reviewed Ms Sanderson's mental health. The nurse noted that Ms Sanderson was quiet throughout and limited in her engagement. Ms Sanderson said that she had no issues or thoughts of harming herself, although she did not feel that her sertraline medication was helping her mood. The nurse advised her to continue with it and they would review the medication again in two weeks if Ms Sanderson still felt there had been no improvement.

40. On 1 October, an assistant practitioner from the substance misuse team reviewed Ms Sanderson. Ms Sanderson said that since completing her alcohol detox she had no cravings for alcohol. Ms Sanderson also said that she had a good support network. The practitioner noted that Ms Sanderson said that she had no concerns about her physical or mental health, and that she had no thoughts of suicide or self-harm.

41. On 9 October, a pharmacist spoke to Ms Sanderson about her sertraline prescription, as she had not been collecting it for the past few days. Ms Sanderson said that she struggled to collect it in the morning, so the pharmacist asked a prison GP to change the collection time to the afternoon and told the mental health team that Ms Sanderson had not been taking her prescription. The following day, a prison GP changed the collection time for Ms Sanderson's prescription to the afternoon.

42. On 26 October, the mental health team leader reviewed Ms Sanderson. She noted that Ms Sanderson had had a difficult childhood and had engaged in previous acts of self-harm and suicide. She also noted that Ms Sanderson had used drugs and alcohol to manage her emotions, and that these substances increased her risk.

She assessed that Ms Sanderson presented a low risk of self-harm, suicide or accidental injury.

43. On 28 October, an officer checked Ms Sanderson's welfare. She said that she was fine, coping well and had no issues.

44. On 2 November, a pharmacist telephoned Ms Sanderson to discuss her sertraline prescription. The pharmacist noted that Ms Sanderson did not sound low in mood, though she said that her symptoms had not improved. Ms Sanderson said that she did not have any thoughts of suicide or self-harm. The pharmacist increased Ms Sanderson's sertraline prescription and planned to review her in four weeks.

45. On 4 November, an officer checked Ms Sanderson's welfare. She said that she had been 'okay' during lockdown, was maintaining contact with her family and had no issues or concerns. The next day, her offender supervisor called Ms Sanderson, and they discussed her plans for release, including a possible referral to live in an approved premises (AP) after release. Ms Sanderson was not keen to go to the AP as she thought people would be using drugs there. From 11 November to 23 November, Ms Sanderson self-isolated in her cell due to testing positive for COVID-19.

46. On 25 November, a nurse reviewed Ms Sanderson who said she felt that the sertraline was not working, and she wanted a medication review. The nurse noted that Ms Sanderson was due a medication review due to a recent increase in the dosage.

47. On 2 December, a Shelter resettlement worker spoke to Ms Sanderson, who said that she wanted to move to Leyland to live with her girlfriend when she was released. The worker explained that, as Ms Sanderson had no connection to that area, she would not be able to do this when released. She noted that Ms Sanderson seemed to understand.

48. On 7 December, an officer checked Ms Sanderson's welfare and noted that she had no issues to report. Staff also submitted an intelligence report as Ms Sanderson was found lying on the same bed as another prisoner. The report noted that staff should monitor the situation and separate the prisoners if they were proved to be in a relationship since this was against prison policy.

49. On 8 December, the offender supervisor called Ms Sanderson and they discussed potential release addresses since there were no vacancies in APs. Ms Sanderson was glad about this and said she wanted to live with her partner in a different area. The offender supervisor explained again that it was unlikely this would be approved, and they spoke about her getting short-term accommodation from the local authority. She said that Ms Sanderson seemed to accept this.

50. Also, on 8 December, an officer found Ms Sanderson and her cellmate lying on a bed together. When challenged, the prisoners said they were just friends. Prisoners told the officer that they did not know whether Ms Sanderson was in a relationship with the other prisoner. Other staff the investigator spoke to did not know of any alleged relationship between the two prisoners.

51. On 9 and 11 December, a pharmacist tried to telephone Ms Sanderson to discuss her sertraline prescription, but she did not answer. The pharmacist noted that Ms Sanderson had been missing some of her medication so planned to try to speak to her again.

52. On 11 December, Ms Sanderson was sentenced to a further 12 weeks' imprisonment for assault. Her new release date was 21 January 2021. On 15 December, the offender supervisor telephoned Ms Sanderson to discuss her new sentence. The offender supervisor explained that the new sentence allowed for more appropriate accommodation to be found for Ms Sanderson's release, though she noted that Ms Sanderson seemed to be indifferent. Ms Sanderson said that she was 'okay' and did not report any issues.

53. On 15 December, Ms Sanderson rang her partner, who said she was going to be sectioned. Ms Sanderson sounded upset about this and when her partner asked how things were going in prison, she said that they were not going well and she "could not be bothered". On 16 December, Ms Sanderson rang her sister. She said that she could not wait to be released on 21 January.

54. On 17 December, the mental health team leader and a nurse reviewed Ms Sanderson's mental health. It was a brief meeting as Ms Sanderson was on her way to the Stepping Stones group which she said she was looking forward to. Ms Sanderson engaged well but said that she still did not think her sertraline was helping and wanted a medication review. The team leader noted that they decided to discharge her from the mental health team into the care of the prison GP for a medication review. The team leader told the investigator that Ms Sanderson seemed settled and did not seem worried about being released in January 2021. The nurses also said that they would come and see her once more before she was released.

55. The same day, Ms Sanderson applied for help contacting Lancashire Women (a charity working to empower women to transform their lives), as she planned to move to Leyland.

56. On 18 December, a pharmacist tried to telephone Ms Sanderson again to discuss her sertraline prescription, but again she did not answer. She planned to try the following week.

57. That evening, Ms Sanderson tried to phone her partner eight times but was unsuccessful in getting through. She left a voicemail stating that she assumed they had taken her partner's phone and she hoped she was okay.

58. On 18 December, Ms Sanderson rang her mother. Ms Sanderson again spoke about looking forward to her release and that she would ensure she did not return to prison.

59. On 19 December, staff submitted an intelligence report that Ms Sanderson was potentially in a relationship with her cellmate.

60. The same day, Ms Sanderson rang her partner who was in a secure psychiatric hospital and wanted to go home. Ms Sanderson tried to reassure her and said she

would visit her when she was released. The next day, she rang her partner twice, but she did not get through.

61. Ms Sanderson's offender manager told the investigator that Ms Sanderson was "bubbly", "chatty" and "confident". She said she never had any concerns that Ms Sanderson would harm herself. She thought that Ms Sanderson had a good relationship with staff and other prisoners.

62. A prisoner who lived in the same house as Ms Sanderson told police that Ms Sanderson was "the life and soul of the house" and got on well with everyone. She said that she thought Ms Sanderson had a good relationship with her partner in the community and was looking forward to being released and seeing her. However, she said that she was aware that Ms Sanderson and her partner argued quite regularly on the telephone.

63. On 21 December, staff found Ms Sanderson with her top off on the same bed as her cellmate. Ms Sanderson said she had just woken up and was reminded to dress appropriately at all times. Staff submitted an intelligence report questioning whether the two prisoners were in a relationship. Ms Sanderson's cellmate was due to be released on 24 December.

64. At 5.50pm, Ms Sanderson rang her partner who said that she had been restrained twice that day in the secure hospital, as she had tried to hang herself. They joked about Ms Sanderson's partner not being allowed a vape and then the call disconnected seemingly because of her partner having a poor signal. Ms Sanderson's cellmate, Ms X, told police that Ms Sanderson was upset by this phone call. Ms Sanderson told her that her partner had been screaming at her and blaming her for her declining mental health. (Prison staff listened to a recording of the call and this was not the case.) Ms X said that Ms Sanderson seemed "more annoyed than upset on the face of it, but knowing Ms Sanderson always put on a brave face". She said she tried to reassure Ms Sanderson that her partner's mental health was not her fault. They went downstairs to watch television in the common room and Ms X said that Ms Sanderson's mood seemed to improve. Ms X told police that Ms Sanderson had never told her that she had suicidal thoughts.

65. Around 9.00pm, Ms X told police that they both returned to their cell, lay down on the bottom bunk and that she went to sleep. Officer A and Officer B did the roll count of prisoners on Davies House between 9.00pm and 9.30pm. Officer A told the investigator that she had no concerns about any prisoners at that time. There is no CCTV footage covering Ms Sanderson's room.

66. A prisoner said that sometime between 9.30pm and 10.30pm, Ms Sanderson came to her cell and asked her and her cellmate to practice a dance that they were supposed to be performing on 26 December. Both prisoners said they were tired and did not want to which Ms Sanderson joked about and left the cell.

Events of 22 December

67. On 22 December at approximately 5.50am, Officer A and Officer B returned to Davies House to complete the morning roll check. Officer B looked in through Ms Sanderson's observation panel and saw her hanging from a ligature tied to her bunk bed. Officer B shouted to Officer A, who was very close by, and they immediately

went into Ms Sanderson's room. The officers cut Ms Sanderson down using an anti-ligature knife. Officer A told the investigator that Ms Sanderson had used a flag, as a ligature. Ms X told police that they had got this flag from another houseblock and it had been draped over a chair in their room that evening.

68. Officer B noted that Ms Sanderson was purple and rigid. She started chest compressions while Officer A took Ms X, who had just woken up, to the cell next door. Officer A then radioed for immediate healthcare assistance. A nurse and a healthcare assistant responded to the request straight away. The nurse estimated it took them two to three minutes to get to Ms Sanderson.

69. The nurse asked the officer doing chest compressions to step aside so that they could assess Ms Sanderson. On seeing Ms Sanderson, the nurse immediately asked the healthcare assistant to get the defibrillator and radioed the control room to request an ambulance. The nurse noted that Ms Sanderson showed signs of rigor mortis, as her skin was mottled, and her hands were stiff. She continued chest compressions. Healthcare staff attempted to insert an airway but were unable to due to Ms Sanderson having a stiff jaw. The nurses administered oxygen and attached a defibrillator (which did not detect a shockable heart rhythm and advised to continue CPR).

70. The paramedics arrived, assessed Ms Sanderson and asked staff to stop CPR. They noted that Ms Sanderson showed signs of rigor mortis and, at 6.13am, pronounced that she had died.

71. After Ms Sanderson's death, police found notes in her cell which they suspected she had written. They are undated. She wrote that she felt worthless and disgusting due to events that had happened in her past. Ms Sanderson also wrote, "I wish myself dead" and "I'd be better off in a grave".

72. After Ms Sanderson had died, prisoners on her house told the mental health team leader that she had been in a relationship with Ms X, that they had had an argument the night before Ms Sanderson was found dead and that Ms X had gone to bed early.

Contact with Ms Sanderson's family

73. Following Ms Sanderson's death, the Head of Residence was appointed as the family liaison officer (FLO). At approximately 10.30am, the Deputy Governor and the Head of Chaplaincy visited the home address of Ms Sanderson's mother and broke the news of her death. Both offered their condolences and support.

74. Later that day, Ms Sanderson's aunt telephoned the prison, and the FLO answered her questions. He continued to support Ms Sanderson's mother and aunt until her funeral. The prison offered to contribute towards the costs of the funeral in line with national instructions.

Support for prisoners and staff

75. After Ms Sanderson's death, the Governor debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues

arising, and to offer support. The care team also offered support. The Deputy Governor and the Head of Safety also spoke to staff individually and offered support.

76. A CM gathered all the prisoners from Ms Sanderson's house into the common room and informed them of her death and offered support. The Deputy Governor also spoke to these prisoners. Ms X was relocated to another cell and staff sought to support and reassure her. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Ms Sanderson's death. A psychological wellbeing practitioner also later spoke to prisoners in Ms Sanderson's house.

Post-mortem report

77. The post-mortem report was not available at the time of issuing this report. However, the coroner recorded Ms Sanderson's preliminary cause of death as compression of the neck due to hanging.

Findings

Assessment of risk and ACCT management

78. Ms Sanderson was subject to ACCT support from 29 June until 7 July. The management of this ACCT involved consistent staff and a nurse from the mental health team. However, we do have some other concerns. The caremap only contained one action, for Ms Sanderson to compete her alcohol detox, which we do not consider adequately reflected the complexity of Ms Sanderson's needs at the time. In addition, staff did not consider involving Ms Sanderson's mother and the post-closure review was completed outside of guidelines. We are also concerned that an ACCT was not opened sooner given Ms Sanderson's disruptive and bizarre behaviour, her detoxification from alcohol, her history of self-harm and attempted suicide and also staff observing that there were potential ligatures hanging out of her cell on 27 June. We make the following recommendation:

    The Governor and Head of Healthcare should ensure that staff manage prisoners at risk of suicide or self-harm in line with national guidelines and all known risk factors are considered when identifying and managing the level of risk of suicide and self-harm.

79. After 7 July, Ms Sanderson was not assessed as presenting a risk of harm to herself. She appeared to settle well at the prison, received regular mental health support and consistently told staff she had no thoughts of suicide or self-harm. The notes that we suspect Ms Sanderson wrote (although we do not know when they were written) indicated that she had not shared the depths of her distress with staff. Since Ms Sanderson's telephone calls were not being monitored, staff were also unaware that Ms Sanderson's partner had been sectioned and had tried to hang herself on 21 December. In these circumstances, we do not consider that staff could have been expected to predict or prevent Ms Sanderson's actions on the night she died.

80. Prison Service Instruction (PSI) 64/2011 governs the management of suicide and self-harm in prisons and requires that the removal of personal possessions to reduce an individual's risk is kept to a minimum. As Ms Sanderson was not considered at risk of suicide and self-harm when she died, we consider that it was reasonable that staff did not remove the flag she had in her cell. Prisoners use a variety of items, including clothes and bedding, as ligatures and it would not be appropriate to remove everything that could be used as a ligature except in extreme circumstances.

Clinical care

81. The clinical reviewer concluded that Ms Sanderson's physical, mental health and substance misuse care were of a good standard and equivalent to that she could have received in the community.

82. Ms Sanderson was regularly reviewed by the mental health team and had an appropriate mental health care plan. The clinical reviewer concluded that Ms Sanderson was well supported by mental health nurses and did not require referral to a psychiatrist or psychologist.

83. When prescribed sertraline, Ms Sanderson was not initially compliant with her medication. She said this was because she had been unaware it had been prescribed. We note the clinical reviewer has made a recommendation about this. The time of the administration of Ms Sanderson's medication was changed in accordance with her wishes and the dose increased appropriately when she said she did not think the medication was working.

84. Ms Sanderson's mother expressed concerns that Ms Sanderson may have been hoarding medication, paracetamol and sertraline. Ms Sanderson was not prescribed paracetamol and did not have her sertraline in her own possession. She was supervised when she collected her medication daily. It would have therefore been extremely difficult for her to stockpile her medication and there is no evidence that she did so. The toxicology report may confirm the levels of sertraline in Ms Sanderson's body when she died but this was not available at the time of issuing this report.

Meaningful contact

85. A CM told the investigator that at the time Ms Sanderson was at Styal there was no formal requirement for staff to do regular welfare checks. From the end of December 2020, staff were expected to do weekly or monthly wellbeing checks with prisoners depending on their level of need, which were very similar to key working sessions in male prisons. The key worker scheme is a key part of HMPPS's response to self-inflicted deaths, self-harm and violence in prisons. It is intended to improve safety by engaging with people, building better relationships between staff and prisoners and helping people settle into life in prison. We understand that the intention was to introduce the key worker scheme at Styal at the end of April 2021.

86. Despite this, between June and December, there is a record of staff doing eleven welfare checks with Ms Sanderson, the last of which was on 7 December. Eight different members of staff completed these checks, and all the entries were very brief, mainly indicating that Ms Sanderson said she had no issues to report. These checks decreased in frequency and Ms Sanderson was only checked monthly for the last three months of her life.

87. We recognise that there was no requirement in place at the time Ms Sanderson was at Styal for staff to complete welfare checks and we are not critical of the officers concerned who appear to have done more than was required of them. However, we are concerned that the lack of structured, regular checks on prisoners in place, with a consistent member of staff, was a missed opportunity to try to identify prisoners, such as Ms Sanderson, who were in distress.

88. We appreciate the difficulties that COVID-19 has presented in terms of maintaining meaningful interaction between staff and prisoners and welcome the prison's planned introduction of the key worker scheme. However, we make the following recommendation:

The Governor should ensure that the key worker scheme is properly embedded and that key workers are allocated sufficient time for an average of 45 minutes per prisoner per week for delivery of the key worker role.

Emergency code

89. Prison Service Instruction (PSI) 03/2013, *Medical emergency response codes*, says that the Governor must have a medical emergency response code protocol that ensures an ambulance is called automatically in a life-threatening medical emergency. The protocol gives guidance on efficiently communicating the nature of a medical emergency, ensuring that staff take the correct equipment to the incident and that there are no delays in calling an ambulance. It explicitly states that all prison staff must be made aware of, and understand, the protocol and their responsibilities during medical emergencies.

90. Governors are required to have a two-code medical emergency response system based on the instruction. Styal uses code blue to indicate an emergency when a prisoner is unconscious or having breathing difficulties, and code red when a prisoner is bleeding. The control room should call an ambulance immediately when an emergency code is used.

91. When Officer A found Ms Sanderson hanging, she radioed for healthcare assistance. She said she thought she had also used a code blue but was not sure whether she transmitted this over the radio. No other staff the investigator spoke to recalled hearing a code blue. The nurse said that the emergency codes are inconsistently used at Styal. The request for healthcare assistance did not convey that healthcare needed to attend a life-threatening incident immediately, as an emergency code would have done. Healthcare staff attended immediately anyway. As a result, the failure to call an emergency code did not delay the healthcare response for Ms Sanderson, as it might easily have done.

92. However, the healthcare staff were not prepared for the situation they were to encounter and did not bring the defibrillator with them as they would have done when responding to an emergency code. The failure to call an emergency code also meant that control room staff did not call an ambulance immediately and this led to a delay of around three minutes before an ambulance was called.

93. Rigor mortis was present when Ms Sanderson was found, meaning that she had been dead for some hours. The failure to call an emergency code did not, therefore, affect the outcome for Ms Sanderson but it could make a critical difference in other medical emergencies.

94. We have identified this issue in three of our previous fatal incident investigations in the last two years at Styal. Styal responded that they have a new safety strategy which incorporates emergency codes which all staff were to be trained in by March 2021. We are concerned that previous recommendations had not led to more urgent training and not before Ms Sanderson's death. We therefore make the following recommendation:

    The Governor should ensure that all prison staff are made aware of and understand their responsibilities during medical emergencies, in particular that staff efficiently communicate the nature of a medical emergency using the appropriate code.

Resuscitation

95. European Resuscitation Council Guidelines for Resuscitation 2015, which were shared with prison managers in September 2016, introduced new staff guidance about when not to perform CPR. The guidance states, "Resuscitation is inappropriate and should not be provided when there is clear evidence that it will be futile". The guidelines define examples of futility as including the presence of rigor mortis.

96. Officer B started chest compressions despite telling the investigator that Ms Sanderson felt rigid and hard. The nurse continued chest compressions, as she told the investigator that it is prison policy to do so until paramedics arrive. We did not see evidence of this policy. The healthcare assistant said that he was trained to always continue CPR until a trained professional tells him to stop. It is clear that Ms Sanderson had been dead for some time and when the paramedics arrived, they asked staff to stop CPR.

97. While we understand the wish to continue resuscitation until death has been formally recognised, staff are not required to carry out CPR in these circumstances. Trying to resuscitate someone who is clearly dead is distressing for staff and undignified for the deceased. Following a death at the prison in 2019, where inappropriate resuscitation had taken place, the prison indicated that all staff would be trained in making this decision by May 2021, as part of the new safety strategy. We are concerned that this learning was not embedded more urgently before Ms Sanderson died. We make the following recommendation:

    The Governor and Head of Healthcare should ensure that staff are given clear guidance and check their understanding about the circumstances in which resuscitation is inappropriate in accordance with European Resuscitation Council Guidelines.

Relationship with cellmate

98. Staff had some concerns in the weeks before Ms Sanderson died that she may have been in an intimate relationship with her cellmate, Ms X. After Ms Sanderson died, prisoners told the mental health team leader that she had been in a relationship with Ms X and that they had had an argument the night Ms Sanderson died.

99. Styal's safety strategy includes a section on managing relationships. This states that prisoners suspected to be in an intimate relationship must not be located in the same houseblock in the prison as, if such relationships break down, the prisoners' risk to themselves may increase. The strategy instructs that if staff suspect prisoners are in an intimate relationship, they must submit an intelligence report and inform a residential SO. There needs to be evidence of an intimate relationship for prisoners to be separated. It has not been possible for the investigator to confirm whether Ms Sanderson was in a relationship with Ms X or whether she had had an argument with Ms X the night before she died. We therefore we make no recommendation in this regard.

Inquest

100. The inquest into Ms Sanderson's death concluded that the cause of her death was suicide.

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