Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Ms Rachel Tunstill, a prisoner at HMP Styal, on 1 August 2023

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

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. If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

3. Ms Rachel Tunstill died in hospital of breast cancer on 1 August 2023, while a prisoner at HMP Styal. She was 32 years old. We offer our condolences to Ms Tunstill's family and friends.

4. The PPO family liaison officer wrote to Ms Tunstill's parents to explain the investigation and to ask if they had any matters they wanted us to consider. They wanted to know about the events that led to Ms Tunstill's death and asked for a copy of our report.

5. NHS England commissioned an independent clinical reviewer to review Ms Tunstill's clinical care at HMP Styal. The clinical reviewer concluded that the clinical care Ms Tunstill received at Styal was of a good standard and equivalent to that which she could have expected to receive in the community. She made one recommendation not related to Ms Tunstill's death that the Head of Healthcare will wish to address.

6. The PPO investigator investigated the non-clinical issues relating to Ms Tunstill's care. We did not find any non-clinical issues of concern. We make no recommendations.

7. We shared our initial report with HMPPS. They found no factual inaccuracies in this report but pointed out a factual inaccuracy in the clinical review which has been amended.

8. We sent a copy of our initial report to Ms Tunstill's parents. They pointed out a factual inaccuracy in the clinical review which has been amended.

9. The inquest, held on 31 January 2024, concluded that Mr Tunstill died from natural causes.

Adrian Usher **January 2024**
Prisons and Probation Ombudsman

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