

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Baby B at HMP&YOI Styal on 18 June 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*



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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.

On 18 June 2020, Ms B, who was a prisoner at HMP Styal, gave birth to a stillborn baby (Baby B) in the prison. Ms B was not aware she was pregnant until Baby B was delivered and we have not found any evidence that staff missed obvious signs that she was. This does not diminish Ms B's terrifying, painful and traumatic experience or the effects on the staff present, which were profound. Even at a distance this is a deeply sad and distressing case.

I am concerned that there were missed opportunities to identify that Ms B needed urgent clinical review during the evening of 18 June. An officer rang the duty nurse three times out of concern for Ms B's physical health, but the nurse did not go and see her and failed to fully assess Ms B's clinical situation. Ms B's symptoms might have indicated a variety of acute conditions and we consider that this was a serious error of judgment.

Regardless of the cause, it is not acceptable that a prisoner should be in unexplained acute pain for several hours without proper assessment or consideration of pain relief. Had proper triage taken place, Ms B might have given birth in hospital with proper clinical support and medication instead of in a prison toilet with untrained staff. We have made a recommendation that the duty nurse's practice should be reviewed and consideration given to whether there is a need to involve the Nursing and Midwifery Council.

My investigation into the death of a baby in another prison in 2019, found that there was no guidance to staff on what to do in the event of an unexpected birth. As this was also the case in Styal, I make a national recommendation that guidance be provided to all staff in women's prisons.

My investigation also found gaps in prison nurse training about reproductive health, long-acting reversible contraception and recognition of early labour. The current initial and secondary health assessment templates used in all prisons do not reflect the gender specific standards introduced by Public Health England and do not readily facilitate the discovery of denied pregnancy (the clinical term for when a woman is unaware of, or unable to acknowledge, the existence of her pregnancy). I also make recommendations to remedy these issues in all women's prisons.

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

Sue McAllister CB
Prisons and Probation Ombudsman

June 2021

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1. HMPPS Action Plan

Summary

Events

1. On 2 March 2020, Ms B was sentenced to 35 weeks imprisonment for assault by beating, criminal damage and using threatening words and behaviour. She arrived at HMP Styal the same day. It was her first time in prison.
2. A nurse completed an initial health assessment. She asked Ms B whether she was pregnant and offered her a pregnancy test. Ms B said it was not possible she was pregnant because she did not have sexual relationships with men. She declined the pregnancy test.
3. From April, she shared a room with another prisoner, Ms X.
4. Over the next few months, Ms B did not report any obvious symptoms of pregnancy. None of the staff or prisoners we interviewed, including Ms X, thought Ms B looked pregnant or considered she might be.
5. On 18 June at about 1.00pm, Ms B began bleeding from her vagina. She said she assumed she was having a period. When Ms B collected her antidepressant medication from a pharmacy technician at about 2.30pm, she did not mention any pain, bleeding or other physical symptoms.
6. Ms B continued to pass a lot of blood and at about 5.00-5.30pm, she began complaining of pain. She and Ms X assumed that she was having a painful period. As time passed, Ms X suggested Ms B might be in labour, but Ms B was adamant that there was no possibility that she was pregnant.
7. At about 6.45pm, Ms X told a Supervising Officer (SO) that Ms B was bleeding, had severe stomach cramps, and had not had a period since November 2019. The SO went to see Ms B. She was in a lot of pain and her stomach was swollen. The SO asked her if she could be pregnant, but Ms B said that was not possible. The SO contacted the duty nurse who said Ms B was just having a painful period, that she had been given paracetamol earlier (which was not the case) and there was no need for her to see her.
8. At 7.15pm, the SO contacted the duty nurse again as Ms B was still experiencing a lot of pain. The nurse said she would book Ms B a triage appointment with a nurse for the following day.
9. At 8.09pm, the SO contacted the duty nurse again and said Ms B was getting worse. The nurse said she was just about to end her shift. She handed over to the night duty nurse that Ms B was having a painful period and might ring for paracetamol during the night.
10. Around 8.30pm, a night patrol officer spoke to Ms B who was in a lot of pain. She asked Ms B if she could be pregnant and Ms B said there was no possibility at all. The officer told the SO that she thought Ms B needed to be seen by a nurse. The SO was about to end her shift. Before leaving the prison, she told the Night Orderly Officer that she had contacted healthcare about Ms B three times, but they had not been to see her.

11. At 9.00pm, Ms X pressed the emergency cell bell as Ms B was in so much pain. Two officers responded almost immediately. Ms B was on all fours and they thought she appeared to be in labour, although Ms B said that was not possible as she did not have sex with men. One of the officers accompanied Ms B to the toilet. At 9.06pm, she rang the duty nurse, who arrived within 30 seconds. While the nurse was talking to Ms B, she began to give birth sitting on the toilet. The nurse radioed for an ambulance at 9.10pm, but the prison's radio system had failed a few minutes earlier and, although staff with radios could hear each other, the communications officer in the control room could not hear them.
12. The nurse delivered the baby, who showed no signs of life. Other staff arrived with emergency equipment. A prison GP arrived and said that the baby was clearly dead. Staff wrapped the baby in a blanket and held her.
13. The communications officer was alerted by an officer nearby and called for an ambulance at 9.18pm. However, he could not give any details of the emergency so the ambulance service did not prioritise the call. When staff realised the communications officer could not hear them, an officer ran to the communications room and spoke directly to the 999 operator at about 9.31pm.
14. At 9.43pm, two paramedics arrived, and started CPR. A third paramedic arrived at 9.54pm. He took over CPR for a couple of minutes but at 9.57pm he confirmed Baby B had died and wrapped her in clean towels. At 10.15pm Ms B and Baby B were taken to hospital by ambulance, accompanied by two officers.
15. The hospital wanted to admit her, but Ms B wanted to return to Styal. She arrived back at the prison by taxi at 5.30am.
16. The post-mortem concluded that Baby B was premature and stillborn. There were abnormalities with the placenta and umbilical cord which were likely to have affected blood supply to the baby in the womb.

Findings

17. Ms B did not know she was pregnant until Baby B was delivered on 18 June 2020. No one who came across her in Styal, including her roommate, thought that Ms B was pregnant.
18. Ms B did not report any symptoms that might reasonably have led staff to suspect that she was pregnant before 18 June 2020.
19. Several officers thought Ms B was pregnant when they saw her during the evening of 18 June, but they all accepted Ms B's conviction that she could not be. We do not criticise them for this.
20. The officer on Ms B's houseblock acted appropriately to alert the duty nurse to Ms B's condition and update her when the situation changed.
21. The duty nurse did not review Ms B's record sufficiently or go to see Ms B as she should have done. She failed to fully assess Ms B's clinical situation, and this was a serious error of judgement.

22. There was a communications failure at Styal during the emergency response that led to a delay in calling an ambulance and in providing the ambulance service with sufficient information to properly triage the emergency.
23. All the staff who tried to help Ms B and Baby B during and after the delivery acted with humanity and to the best of their abilities.
24. The initial and secondary health assessments used across the prison estate do not reflect the gender specific standards introduced by Public Health England (PHE) and do not readily facilitate the discovery of denied pregnancy (the clinical term for when a woman is unaware of, or unable to acknowledge, the existence of her pregnancy).
25. There is no guidance to staff on what to do in the event of an unexpected birth.
26. Nurses in women's prisons should have training in reproductive health, long-acting reversible contraception and recognising early labour.

Recommendations

- **The Head of Healthcare and the Director of Nursing for Spectrum should:**
 - **review Nurse 2's clinical practice and consider whether she requires further training and professional support;**
 - **discuss the findings of this report with her personally; and**
 - **consider whether her actions on 18 June 2020 are a matter for local resolution or if they represent a pattern which would require discussion with the Nursing and Midwifery Council.**
- **The Head of Healthcare and the Director of Nursing for Spectrum should ensure that:**
 - **requests from officers for nurses to attend women are always recorded on the clinical record;**
 - **nurses consult the clinical record when triaging calls from officers; and**
 - **all relevant information is handed over at shift changes.**
- **The Director of Health and Justice for NHS England should ensure that nurses in women's prisons receive training in recognising the signs of early labour.**
- **The Head of HMPPS Women's Team, in conjunction with NHS England, should provide guidance for all staff in women's prisons on what to do in the event of an unexpected birth. This should emphasise the need to obtain a rapid response from the ambulance service to guide staff through rescue breaths and keeping the baby warm.**

- **The Head of Healthcare and the Director of Nursing for Spectrum should ensure that:**
 - **training is provided for nursing staff in reproductive health; including long-acting reversible contraception; and**
 - **all nurses undertaking secondary healthcare screening should be able to demonstrate competence in basic reproductive health as defined in the Royal College of Nursing’s sexual health education directory.**
- **The Director of Health and Justice for NHS England should review the initial and secondary screening tools used in the women’s estate and ensure that:**
 - **both templates reflect the gender specific standards introduced by Public Health England (PHE);**
 - **all pre-menopausal women are offered a pregnancy test at both the initial and secondary health assessments;**
 - **the secondary health assessment template should include provision for a detailed reproductive health and obstetric history to be taken and for a discussion about sexual health, menstrual history and contraceptive history; and**
 - **staff should receive operational guidance on taking a trauma-informed approach to discussing this area of women’s health.**
- **The Director of Health and Justice for NHS England should develop a system where a pregnancy test is routinely offered before a medication that is known to or has the potential to affect a foetus is prescribed or continued.**
- **The Governor and Head of Healthcare should share this report with the staff named in it and give them the opportunity to discuss it in a supportive environment.**

The Investigation Process

27. 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.
28. The investigator obtained copies of relevant extracts from Ms B's prison and medical records, CCTV and radio transmissions. Further evidence was obtained from North West Ambulance Service and a Consultant Obstetrician at Wythenshawe Hospital.
29. NHS England commissioned Nina Murphy Associates to review Ms B's clinical care at the prison. An independent clinical reviewer undertook the clinical review. The investigator and the clinical reviewer interviewed 14 members of staff and two prisoners in October, November and December 2020. All the interviews were conducted by video conference and telephone due to the restrictions in place during the COVID-19 pandemic. They also spoke to a former employee of Family Action, a charity which provides support services to women at Styal and Birth Companions, a charity supporting pregnant women in prison.
30. The investigator and the clinical reviewer met Ms B and her solicitor twice via video conference during the investigation to hear about her experience and answer questions. Ms B asked for as much detail as possible about the events of 18 June 2020, in particular why a nurse did not come and see her on 18 June. We have sent her a copy of this report.

Background Information

HMP&YOI Styal

31. 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.
32. Spectrum Community Health runs healthcare services at the prison. Greater Manchester 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.

HM Inspectorate of Prisons

33. The most recent inspection of HMP Styal was in May 2018. Inspectors reported that the population was complex and ranged from women on remand and those serving short custodial sentences to women serving life sentences. Nearly all the women that arrived at the prison had significant needs, including many with a history of suicide attempts and self-harm, mental health issues and substance misuse. They were often vulnerable and had experienced trauma, abuse and domestic violence.
34. Inspectors found that the healthcare service was well led, with effective patient engagement by a skilled and dedicated team. Clinical and managerial supervision had been embedded since the previous inspection. Professional development opportunities were very good and mandatory training well managed. There was an active approach to reporting and learning from incidents.

Independent Monitoring Board

35. 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 2020, the IMB reported that over 80% of prisoners were generally satisfied with their healthcare and felt listened to. The main areas of complaint were access to the GP and issues with getting medication.

Initial and secondary health assessment in prison

36. The initial health assessment takes place in reception when a prisoner first arrives in prison. Its purpose is to ensure first night safety in compliance with NICE Guideline 57 (NG57 Physical health of people in prison) and NICE Guideline 66 (Mental health of adults in contact with the criminal justice system). As part of the assessment staff are required to identify issues that affect the person's immediate health and safety and priority health needs.
37. Page 17 of the initial assessment covers female health conditions. The first question is, "Does the woman have reason to think she is pregnant, or would she like a pregnancy test?" Underneath there is a box to record the date of the last menstrual period (LMP), a checkbox to indicate whether a urine pregnancy test has been requested and a box to indicate whether the patient has been advised

to have a pregnancy test. The LMP relates to the pregnancy test and is relevant to knowing how far advanced the pregnancy is.

38. The secondary assessment is a more in-depth assessment designed to elicit additional information and to assess, treat or refer on previously unidentified health needs. It should take place within seven days of arrival in prison. Prisoners are asked to provide a urine sample, but pregnancy is not routinely tested for unless the prisoner suspects she is pregnant. Sexual health advice is one of several subjects listed in the 'advice' section but there are no specific questions indicated.
39. Both assessments follow templates based on the standardised prison health reception tool developed by Professor Don Grubin.

Simple medication policy

40. This policy allows healthcare staff to supply and administer a specified number of basic medications, such as paracetamol, without a prescription. According to NICE guidance, medicines should not be given under this policy for more than three consecutive days (72 hours) without review.

Key Events

41. Ms B told the investigators that she was completely unaware that she was pregnant before 18 June 2020. She said she had a contraceptive implant removed in February 2019 and had her last menstrual period in November 2019. She said that during the events of 18 June 2020, she remembered an incident in September 2019, when she had woken up in unfamiliar surroundings with no memory of the night before. She said that she suspected that her drink had been 'spiked'.

2 March – 17 June 2020

42. On 2 March 2020, Ms B was sentenced to 35 weeks imprisonment for assault by beating, criminal damage and using threatening words and behaviour. She arrived at HMP Styal the same day. It was her first time in prison.
43. At about 7.30pm, Nurse 1 completed an initial health assessment using the standard template. She asked Ms B whether she was pregnant or thought there was any possibility that she could be pregnant and offered Ms B a pregnancy test. Ms B said it was not possible she was pregnant because she did not have sexual relationships with men. She declined the pregnancy test.
44. Nurse 1 said at interview that Ms B said her menstrual cycle was irregular and she had not had a period for about two months. Nurse 1 said Ms B was certain there was no possibility that she was pregnant, and she had not, therefore, asked more probing questions about her periods. She did not record a date for Ms B's last menstrual period in the box on the template and did not refer to this conversation on Ms B's record. Nurse 1 said she did not advise Ms B to have a pregnancy test because Ms B said she did not have sex with men.
45. On 3 March, a healthcare assistant completed a follow up health assessment. Ms B said she was up to date with all vaccinations and declined sexual health and blood borne virus screening. The secondary health assessment does not include questions about reproductive health, menstrual or contraceptive history and the offer of a pregnancy test is not repeated.
46. On 15 March, Ms B was prescribed mirtazapine (an antidepressant).
47. In April, Ms B was given a room in Davies House. She shared a room on C3 landing with Ms X.
48. There are no entries on Ms B's clinical record during this period that indicate that she reported any obvious symptoms of pregnancy or that staff were suspicious that she was pregnant. None of the staff or prisoners interviewed thought Ms B looked pregnant or considered she might be. On 15, 16 March, 20, 21 April, 3, 20 May and 9 June, Ms B received pain relief via the simple medication policy, but the reasons are not recorded on her clinical record.
49. Ms B told the investigators that she had experienced gurgling in her stomach, heartburn, bloating and wind but had attributed this to prison food. She said it had sometimes been possible to see movement in her abdomen and she and her room-mate Ms X had jokingly referred to this as her "baby".

50. Ms X said she had had four children and that during the months she shared a room with Ms B, Ms B did not look pregnant. With hindsight she realised that some of Ms B's symptoms indicated pregnancy – the type of food she ate, her stomach cramps and wind – but at the time she did not consider the possibility that Ms B was pregnant.

18 June 2020

51. On 18 June, Ms B said that, during the early part of the day she had general abdominal discomfort consistent with having a period. At about 1.00pm she passed a blood clot through her vagina and some bleeding followed. She assumed she was having a period and, as her menstrual cycle had been erratic for some time, she did not think this was unusual. (It is not clear when Ms B began bleeding. The pathologist recorded in the post-mortem report that Ms B passed a blood clot at about 1.00pm, presumably after being told this was the case. Ms B confirmed this timing when the investigator and clinical reviewer spoke to her. However, Ms B also told us that she did not begin bleeding until about 4.00pm when she said she passed a blood clot.)
52. At 2.27pm, a pharmacy technician, provided Ms B with her antidepressant medication. Ms B did not mention any pain, bleeding or other physical symptoms.
53. During the afternoon, Ms B said she became more and more uncomfortable and at about 4.00pm she said she had a “gurgling” feeling in her stomach.
54. Ms X told us that Ms B began complaining of pain at about 5.00 – 5.30pm. Before that Ms B told her that she had passed a lot of blood in the toilet. At the time she said they both assumed that Ms B was having a painful period.

6.00pm – 7.00pm

55. Ms X said Ms B kept getting up and down and going to the toilet. She told Ms B that she was sure she was in labour, but Ms B said she could not be. Ms B told her she had not bled so much during a period before. With hindsight Ms X said that she thought that Ms B's waters must have broken but did not think this at the time.
56. CCTV shows Ms X went downstairs to see the Davies House Supervising Officer (SO) C, at 6.48pm. Ms X said she told SO C that Ms B was bleeding, had severe stomach cramps, had a contraceptive implant fitted and had not had a period since November 2019.
57. CCTV shows SO C and Ms X went to see Ms B together at 6.49pm. SO C said Ms B was standing over her bed, doubled up in pain. Ms B told her the bleeding and stomach cramps had started an hour before, were coming and going and were getting worse. SO C asked Ms B to lie down and looked at her stomach. She said Ms B's stomach was swollen. She asked Ms B if she was pregnant, and Ms B replied that she could not be. Ms X said SO C said to Ms B, “[name] you look six months pregnant.”
58. SO C told Ms B she would ring for a nurse and asked Ms X to stay with Ms B. SO C told the investigators that she believed Ms B's assertion that she could not

be pregnant and was therefore worried that Ms B had something seriously wrong with her because her abdomen was significantly distended.

59. Radio transmissions show that at 6.55pm SO C radioed for the nurse on duty to contact her by telephone.
60. Nurse 2 rang SO C back. (The prison's internal telephone calls are not recorded so we do not know the exact time or content of this call.) SO C told us she relayed that Ms B was bleeding, in pain and had a contraceptive implant. She said Nurse 2 told her she would make Ms B an appointment to have her implant removed in the next few days and she would ask night staff to bring Ms B some pain relief. SO C said she asked Nurse 2 if she was going to come and see Ms B and Nurse 2 replied that Ms B was just having a period. SO C said she asked Nurse 2 if it was normal to have such a distended stomach during a period and reported her observation that Ms B looked about six months pregnant. She said Nurse 2 said it was perfectly normal and Ms B just needed to have her implant removed.
61. Nurse 2 told us she remembered being told that Ms B was bleeding from her vagina and had a contraceptive implant but not that she was in pain. She said she decided she did not need to go and see Ms B because SO C sounded calm, there was nothing in her tone to cause her to worry and the officer had not called an emergency code.
62. Nurse 3 said that she remembered Nurse 2 speaking to an officer on the telephone just before she went home that night. (Nurse 3 had worked a 12.5 hour shift that started at 7.00am that day, so she went home at or after 7.30pm.) Nurse 3 said that, while Nurse 2 was on the call, she told her that Ms B might have been one of three women that she had given paracetamol to for period pain at about 5.00pm (she was not). We cannot be definitive about the time of Nurse 3's intervention but on the balance of evidence we are satisfied it took place during this call.
63. Nurse 2 said she told SO C that Ms B had received paracetamol at evening medication. She did not open Ms B's record to check her medical history and whether she had been given paracetamol. Neither did she record the conversation with SO C.

7.00pm – 8.00pm

64. CCTV shows SO C reported back to Ms B at 7.08pm. Ms B said Ms X had given her the wrong information and her contraceptive implant had been removed in February 2019. SO C said Ms B was visibly distressed when she told her the nurse was not coming to see her. Ms B told her that she had "never known pain like this".
65. CCTV shows SO C left Davies House for a break at 7.11pm. At 7.15pm, she radioed Nurse 2 and told her that Ms B had already had her contraceptive implant removed. She also told her that Ms B had not had a period since November 2019. Nurse 2 said she would book Ms B a triage appointment with a nurse for the following day. SO C said, "As long as you are happy that it's still just a period that's fine." Nurse 2 said, "Yes, that's fine". SO C asked if the night

nurse would still bring Ms B some pain relief and Nurse 2 confirmed they would. (As this conversation was by radio it was recorded.)

66. Nurse 2 remembered that SO C had contacted her again to say that Ms B was still bleeding. She reiterated that SO C did not sound alarmed and had not called an emergency code.
67. Nurse 2 opened Ms B's clinical record at 7.27pm and made her an appointment with a nurse for the next day. In her statement written on 19 June, Nurse 2 said that she searched Ms B's record for the word 'pregnant' but the search returned no records. At interview she told us she searched for the word 'implant'. She did not make a record of her second discussion with SO C in the clinical record.
68. The Head of Healthcare told us that Nurse 2 made an appointment for Ms B to be seen in triage the following day. (This is not visible on SystemOne but was confirmed by the Head of Healthcare.)
69. SO C said that after she had spoken to Nurse 2, she saw Custodial Manager (CM) F, the daytime orderly officer, and told her that she had asked a nurse to come and see a woman who was in pain but the nurse would not come and see her.
70. CM F said SO C told her that she had a woman with stomach ache and had asked the nurse to attend. The nurse had decided it was period pain and could wait for the night staff to take her some pain relief. SO C was concerned because the woman's stomach was very swollen and she thought it was more than period pain. SO C told her she had asked Ms B if she was pregnant and Ms B had said she could not be. SO C told her Ms B had not had a period for a while and had had a contraceptive implant removed.
71. CM F told SO C that she had personal experience of contraceptive implants and thought Ms B's lack of periods might be related to that. She said SO C did not ask her to intervene. She was not aware that SO C had called the nurse more than once and there was no suggestion that Ms B might be pregnant. CM F said, had there been, she would have asked for an ambulance. She said, at the time, she was dealing with Cheshire police about a criminal matter and she asked SO C to deal with the situation on Davies House. She knew that CM G, the night orderly officer, had already arrived in the prison and advised SO C to make him aware of her concerns.
72. SO C returned to Davies House at 7.25pm and went straight up to see Ms B. She reported what Nurse 2 had said. SO C said Ms B was "close to tears and in a considerable amount of pain".

8.00pm – 9.06pm

73. At 8.05pm, CCTV showed Ms B went downstairs to see SO C. SO C said Ms B was crying and moaning and said she could not stand the pain anymore. SO C said Ms B appeared to have deteriorated. She told Ms B she would call healthcare again and asked her to go back to her room and lie down. At 8.09pm, SO C radioed Nurse 2 and asked her to telephone her.

74. Nurse 2 called SO C back on the telephone, so we do not know the exact content of the conversation. SO C said she told Nurse 2 that Ms B was feeling worse. Nurse 2 told her she was in the middle of handing the details over to the night nurse and Ms B was not allowed any more pain relief until 9.00pm. (Handover is usually between 8.00 – 8.30pm.)
75. SO C reported this to Ms B. Ms B denied being given paracetamol earlier and her clinical records confirmed she had not. Ms B started to walk back up to her room at 8.11pm. She sat on the bottom few stairs for a minute and was obviously in pain. At 8.14pm, CCTV shows her doubled over and on all fours on the landing outside her room. She had a dressing gown on but at 8.15pm her distended stomach was visible on CCTV.
76. Nurse 2 said she did not remember talking to SO C a third time.
77. Nurse 4, the night nurse, said that Nurse 2 handed over to her that officers had called a few times about Ms B who had stomach pains and vaginal bleeding. Nurse 2 said that she had looked at Ms B's records, established it was a period and advised that the woman might ring her cell bell for pain relief in the night. Nurse 4 said the handover included that Ms B had already taken paracetamol and information about a coil. Nurse 4 said she was confused about whether Ms B still had a coil or it had been removed. Nurse 4 said that Nurse 2 was clearly not concerned about the woman.
78. At 8.20pm, SO C wrote in the wing observation book:
- “[Ms B] is having very bad stomach cramps and is bleeding. Hotel 1 [Nurse 2, the duty nurse] contacted three times but would not come out to see her. Tasked night staff with coming to give pain relief and appointment made for triage tomorrow.”
79. SO C said at interview that she was frustrated that Nurse 2 had decided not to come and see Ms B. She said she was concerned about Ms B because she had a distended abdomen that was not explained by pregnancy. She said she felt she had conveyed the severity of Ms B's pain and distress to Nurse 2.
80. CCTV shows that at 8.29pm, night patrol officers L and M arrived on Davies House to complete a roll count. Officer M said she remembered SO C telling her that Ms B was having stomach cramps and her stomach was very swollen. SO C had thought Ms B was pregnant, but Ms B had said she could not be. SO C told her that she had tried to get healthcare to see Ms B.
81. Officer L said she spoke to Ms B and Ms X in their room. Ms B was sitting at her desk in a dressing gown. She said the pain that Ms B was describing sounded like pregnancy and she asked her if there was any possibility that this was the case. Ms B told her there was no possibility at all. Officer L told her she would finish roll count and come back with a nurse. Officer L said that, as pregnancy was ruled out, she thought that Ms B could wait for ten minutes until she returned with a nurse. She did not see Ms B's stomach because it was covered by her dressing gown.

82. Officer L returned to the office and told SO C that she thought Ms B needed to see healthcare. SO C said she agreed with her and had rung them three times. Officer L and Officer M continued their roll count of the other houses.
83. At 8.49pm, CCTV shows SO C left Davies House and a radio transmission at 8.57pm confirmed she was about to leave the prison. She said she saw CM G at the gate and repeated her concerns about Ms B. She said she told him she had contacted healthcare three times, but they had not been to see her.
84. CM G said that SO C told him that she had asked the nurse a couple of times to come over and see a woman on Davies House but the nurse was not concerned and would not come over. He said he was under the impression that SO C had told the nurse that she thought she ought to come and see her.
85. Ms X said that after Officer L left, Ms B told her that she could not stand the pain anymore and Ms X pressed her emergency cell bell. Officer N and Officer O were on patrol outside and entered Davies House at 9.00pm.
86. Officer N said, as she entered Davies House, Ms X shouted to her that Ms B was in “excruciating” pain. Ms B was on all fours in her doorway, sweating and clearly in pain. Officer N tried to establish whether Ms B had taken anything or was allergic to anything. Officer O said Ms B looked like she was in labour. Officer N asked Ms B whether she had had unprotected sex. Ms B said she did not have sex with men. Officer N asked her if she could have been raped and Ms B then recalled an incident the previous Autumn when she thought her drink might have been spiked.
87. At 9.02pm, Ms B left her room accompanied by Officer N. A minute later she went into the toilet. She remained in the toilet with Officer N and Ms X waiting outside at different times.
88. At 9.06pm, Officer N radioed Nurse 4 and asked her to come and see Ms B. She said Ms B was in pain, in the toilet, hunched over and clutching her stomach. Nurse 4 agreed to come over straight away.

Emergency response

89. The communications system at Styal failed that evening and there are no records of radio transmissions between 9.06pm and 11.25pm. The last recorded calls are Officer N to Nurse 4. Staff with radios could hear each other but the communications officer in the control room could not hear them.
90. CCTV shows Nurse 4 arrived at Davies House at 9.06pm about 30 seconds after Officer N’s call. Officer N briefed her on the way upstairs. Ms B was on the toilet. She told Nurse 4 that she had been having stomach pains and vaginal bleeding all day. Ms B recounted the incident when her drink might have been spiked and said her last period had been in November 2019. She described the pain as constant but going off a little and then returning. Ms X said she thought that Ms B was having contractions and she had been timing them. She said Ms B’s contractions were currently 90 seconds apart. Nurse 4 asked Ms B if she was able to leave the toilet to allow her to take some baseline observations, but Ms B said she was not.

91. Ms B said she felt as if she needed to open her bowels. Nurse 4 stepped back to give Ms B some privacy. Shortly afterwards Ms B told her she had been to the toilet but, after looking, said there was a baby. Nurse 4 asked if she could look and saw the legs and torso of a baby emerging from Ms B. She said the baby's head had not been delivered. Nurse 4 immediately radioed for an ambulance, emergency equipment and the healthcare assistant, who was on night duty with her. CCTV shows Nurse 4 used her radio twice at 9.10pm.
92. The healthcare assistant said she heard Nurse 4's radio call but it was muffled. She went straight to Davies House. Officer L and Officer M said they returned to Davies House as soon as they heard the radio call for an ambulance. CCTV showed all three arrived at Davies House within seconds of each other at 9.11pm.
93. Officer N said she also radioed for an ambulance at some point. There was confusion because no one could hear radio confirmation from the control room. CCTV shows Officer N used her radio at 9.14pm.
94. Nurse 4 said she knew that she had to get the baby's head delivered as soon as possible. She said Baby B's torso was already blue. She told Ms B to lie on the floor and push. Ms B said she needed to stand up and the healthcare assistant held Baby B's legs and torso as she did so. The healthcare assistant said Baby B was cold and purple in colour. Ms B had a strong contraction and Baby B's head, the umbilical cord and the placenta were all delivered at once. Nurse 4 said Baby B was cold and mottled in colour and there were no signs of life. The healthcare assistant wrapped Baby B in towels.
95. Ms B went into shock and Nurse 4 gave her oxygen. The healthcare assistant said she also went into shock and handed Baby B to Officer L. CCTV shows the healthcare assistant left the toilet at 9.19pm. She looked distraught and unable to walk properly and had to be helped down the corridor. Officer L said, at first, she thought Baby B felt warm but then she realised that it was the placenta that was warm and Baby B was cold and blue.
96. As soon as the member of staff in the room next to the control room realised that the communications officer was unable to hear the radio calls for an ambulance, they told him in person and he rang for an ambulance. Information from North West Ambulance Service shows the call was received at 9.18pm. By cross referencing the prison's CCTV and information from the ambulance service, we think that the CCTV clock is about four minutes behind the ambulance service clock. This means that there was approximately a four-minute delay between Nurse 4 radioing for an ambulance and the communications officer dialling 999.
97. The investigator listened to the 999 call. The communications officer had no information about why an ambulance was needed. At some point during the call someone else in the room told him that a prisoner had given birth in a toilet and the mother was breathing. An ambulance was allocated but the response was not triaged as high priority.
98. CCTV shows Officer L left the toilet holding Baby B wrapped in towels at 9.25pm.

99. When staff on Davies House asked for an update on the arrival time of the ambulance, they became aware that they could not contact the communications officer by radio. At 9.27pm, CCTV shows Officer O left Davies House. He said he ran to the communications room to ask for an update and arrived as the communications officer was speaking to the 999 operator a second time, prompted by information from staff who could hear requests for updates on the arrival time from staff on Davies House.
100. Officer O spoke directly to the operator and told her that Baby B was not breathing. The operator upgraded the emergency to high priority. The ambulance records showed the second 999 call was received at 9.31pm.
101. At 9.30pm, CCTV shows a prison GP who had been working in reception, arrived on Davies House. He said he had finished his clinic when he realised something was going on and went to investigate. CCTV shows the prison GP looked at Baby B in Officer's L's arms and shook his head. He said the baby was obviously dead. He asked Nurse 4 if she needed him and then left when she said that Ms B's condition was stabilising and an ambulance was on its way.
102. At 9.43pm CCTV shows the first two paramedics arrived at Davies House.
103. Officer L said the first paramedic asked her if staff had attempted CPR and when she said they had not, he said, "You have not done anything at all?" Nurse 4 said she told the paramedic that she had checked Baby B and she had been born dead. The first paramedic took Baby B from Officer L, placed her on the floor, unwrapped her and began CPR.
104. At interview Officer L, Nurse 4 and Officer O were all very distressed when they relayed what the paramedic did and said to them. CCTV showed Officer L left the landing in tears. Officer M, Officer O and Nurse 4 all appeared too upset to watch the attempt to resuscitate Baby B and moved away. The healthcare assistant, who had returned to the landing, knelt next to Baby B while CPR took place.
105. At 9.54pm, another paramedic arrived. He took over CPR for a couple of minutes but at 9.57pm he confirmed Baby B was dead and wrapped her in clean towels. At 10.08pm, he carried Baby B to the ambulance. At 10.15pm Ms B left Davies House and she and Baby B were taken to Wythenshawe Hospital by ambulance.
106. Officer M accompanied Ms B to hospital with another officer. She said they arrived at 10.30pm. On the way there, Ms B appeared to be in shock and still claimed she had not been pregnant. Ms B was told her baby was dead by hospital staff. The hospital wanted to admit her, but Ms B asked to return to Styal to receive support from her friends. She returned to the prison by taxi with Officer M at 5.30am.

Support for prisoners and staff

107. After Baby B's death, a senior prison manager, debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The senior prison manager also met the escort staff when they returned to the prison. The staff care team also offered support.

108. The prison posted notices to staff and prisoners informing them of Baby B's death, and to offer support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Baby B's death.
109. Ms B provided us with a detailed statement of her post-natal care at Styal. Ms B said she received good care after the death of Baby B but she felt that this was too late and she should have been taken to hospital earlier in the evening of 18 June. She said the prison had reassured her that measures had been taken to ensure continuity of care with her community GP after her release but that this had not happened.

Post-mortem report

110. Baby B was classified as stillborn. The hospital post-mortem report showed that her growth and development indicated a gestation of between 27 and 31 weeks, which is considered premature. (This indicated conception in November or December 2019.)
111. The post-mortem found that the umbilical cord was hyper-coiled (a chronic state, usually established during early pregnancy, which can only be detected by a scan) and there were also placental abnormalities, some of which were old, indicating that they had occurred earlier in the pregnancy. Both conditions are associated with risk to the foetus and premature birth, miscarriage and stillbirth. The problems with the placenta in particular were likely to have affected the blood and, therefore, oxygen supply to the baby.

Evidence from a Consultant Obstetrician at Wythenshawe Hospital

112. The consultant obstetrician told the investigator and the clinical reviewer that she was not on duty on the night of 18 June when Ms B and her baby arrived at Wythenshawe Hospital. She was told what had happened by colleagues when she arrived for work the following morning and she contacted the prison to ask them to bring Ms B back to hospital in the afternoon in order to offer her the services of the Rainbow Clinic, a specialist service for women who have suffered a stillbirth. She also saw Ms B for a follow up appointment on 9 October, after which she wrote to her.
113. At interview the consultant obstetrician said that, although it was not possible to be 100% sure, it appeared that Baby B had been alive at the onset of labour (because Ms B had felt what she now thought were foetal movements on the evening of the birth) and that it was likely that she had died during premature labour or during the process of her birth. She said they had not found any other reasons for the stillbirth, although the placenta was not a healthy one and probably had not been supporting the baby's growth to the best of its ability.
114. The consultant obstetrician said that if Ms B had been taken to hospital by 7.30 or 8.00pm, they would have done an ultrasound scan and identified that the baby was in the breech position and would have been able to provide expert help with the delivery. She said that assuming the baby was alive during labour, the outcome "would have been different" if Ms B had been in hospital. She added that she could not say that the baby would have been born in perfect condition,

but she could say that, if the baby had been fine in labour and was stillborn because of the birth itself, they “could have helped”.

115. The consultant obstetrician subsequently wrote to the investigator to say that her interview had been for the purpose of clarifying her involvement in Ms B’s care and should not be seen as an expert opinion for the purpose of a legal claim. She emphasised that she was not an expert witness and that it was important to make this distinction.

Findings

Identification of Ms B's pregnancy

116. Ms B said she did not know that she was pregnant until Baby B was delivered on 18 June. None of the staff interviewed said Ms B looked pregnant before the evening of 18 June. Ms X was probably in the best position to observe Ms B because they shared a room. Ms X, a mother of four children, said she only recognised with hindsight that there were indications that Ms B was pregnant. We consider this to be the clearest indication that Ms B was not obviously pregnant.
117. Aside from telling Nurse 1 that she had not had a period for some two months during her initial health assessment, Ms B did not report any symptoms that might have led staff to suspect that she was pregnant. Nurse 1 said she did not probe the issue with Ms B because Ms B was certain she could not be pregnant as she said she did not have sex with men.
118. We do not criticise Nurse 1 for accepting Ms B's word. We discuss below how the initial and secondary health assessments might inhibit the potential discovery of pregnancy in women who are unaware or in denial that they are pregnant.
119. We do not consider that there were any indications that should have led staff to identify that Ms B was pregnant before 18 June.
120. Several officers thought Ms B was pregnant when they saw her during the evening of 18 June, but they all accepted Ms B's conviction that she could not be. We do not criticise them for listening to, and accepting, what Ms B said.
121. It is not the role of officers to triage clinical presentation. Indeed, doing so might lead to inaccurate information being passed to healthcare or none at all. The role of officers is to alert healthcare when prisoners are unwell and to update them if they receive further information or if the situation changes. We note SO C said she thought Ms B looked six months pregnant in her original call to Nurse 2. We consider SO C and Officer N fulfilled their responsibility to pass their concerns about Ms B to healthcare on 18 June. We discuss Nurse 2's response to this information below.

Nurse 2

122. We have considered Nurse 2's clinical decision making in response to the information provided to her on 18 June.
123. Most women in prison have a number of physical or mental health issues. In addition, levels of self-harm – some very serious – are high. The duty nurse typically receives a large volume of calls from officers as well as being required to respond to emergencies. They must triage a variety of health issues relayed to them second-hand. In order to do this, they have two basic tools: the patient's clinical record and physical review and assessment. Nurse 2 made limited use of Ms B's medical record and did not visit Ms B. We listened to all the radio traffic that evening and there was no other medical emergency between 7.00pm and 9.00pm.

Triage of SO C's first call

124. This call was not recorded and at interview, Nurse 2 said that she did not remember being told by SO C that Ms B was in pain. However, we are satisfied that pain was discussed in the call because during the second call (which was recorded) SO C asked Nurse 2 if the night nurses would “still bring” Ms B pain relief, indicating that it had been raised before.
125. Nurse 2 told us that she concluded that Ms B's condition stemmed in part from her contraceptive implant. It is not clear how she decided this. In addition we note she had very little training in or clinical experience of contraceptive implants. She decided that Ms B's abdominal pain was because she was having a heavy period. She did not appear to take any account of SO C's eye-witness observation during this call that Ms B looked six months pregnant, but seems to have relied instead on indefinite information provided by Nurse 3 that Ms B might have been one of the women who was given paracetamol for period pain at about 5.00pm. Nurse 2 did not check Ms B's medication record to confirm or rule out any of this information.
126. We consider that review of the patient's record is the minimum required for effective clinical assessment. Had Nurse 2 done so, she would have seen that Ms B did not have a contraceptive implant, had no history of abdominal pain or unusually heavy bleeding and had not complained of period pain or been given paracetamol at 5.00pm. This should have prompted her to consider the cause of the pain, to see Ms B for review or to administer pain relief.
127. We note that the administration of paracetamol at 5.00pm would not have precluded Nurse 2 offering Ms B another simple remedy such as ibuprofen at this stage, but she did not appear to consider this either.
128. In addition, Nurse 2 did not record the conversation with SO C or her rationale for the response she gave. This was unacceptable clinical practice and unacceptable record keeping practice.

Triage of SO C's second call

129. Nurse 2 did not thoroughly revisit her conclusions 20 minutes later when SO C clarified that Ms B's implant had been removed over a year previously and she had not had a period since November 2019. This information cast doubt over her initial assessment and should have prompted Nurse 2 to go and see Ms B.
130. Although Nurse 2 now looked at Ms B's record and made her an appointment for the next day, she did not use this as an opportunity to check the medication administration section. This was another missed chance for Nurse 2 to discover Ms B had not received pain relief, which should in turn have prompted her to visit Ms B for this reason alone.
131. Again, Nurse 2 did not record the conversation and her decision making, a further example of unacceptable clinical and record keeping practice.

SO C's third call

132. This took place during handover to the night nurses. We are concerned that the situation was not handed over to Nurse 4 accurately. As she had made no records, Nurse 2 had nothing to prompt her memory. Had events not progressed with such speed, the absence of a proper history of SO C's calls would have undermined Nurse 4's ability to triage the situation in the light of further calls that night.

Nurse 2's decision not to see Ms B

133. Nurse 2 told us that she did not agree to SO C's request to see Ms B because SO C sounded calm and she had not called a medical emergency code. We do not consider that these are valid reasons for not attending a patient. Tone of voice is something that might contribute to the overall picture when making an assessment, but it should not outweigh all other information.
134. The emergency code system, which is used to indicate life-threatening medical emergencies such as a prisoner not breathing or bleeding heavily, was not appropriate in this case. In an environment with multiple health emergencies daily, it is crucial that the emergency code system is not devalued by becoming the only way to ensure a nurse attends a prisoner.

Conclusion

135. We do not consider that Nurse 2 should have concluded from the information provided by SO C that Ms B's situation was a maternity emergency. However, acute abdominal pain can have a variety of causes, some of which are very serious. We consider that the information provided by SO C was sufficient to have caused Nurse 2 to visit Ms B, and that she should have done so.
136. A key question for Ms B is whether her baby could have been born alive if her labour had been identified earlier and she had been taken to hospital. The consultant obstetrician said at interview that if Ms B had been taken to hospital between 7.30 and 8.00pm, assuming the baby was alive during labour the outcome would have been different because they could have provided specialist assistance with the breech birth. However, the consultant obstetrician said that she could not be 100% certain that the outcome would have been different and that she could not say that the baby would have been born in perfect condition. She also asked us to make it clear that in saying this, she was not offering an expert opinion.
137. We are aware that Ms B's solicitors have obtained an expert opinion on this question. We have not referred to it in this report because, although we understand that this is a matter of great importance to Ms B, it is not within the PPO's remit to say whether the baby could have survived and we do not have the clinical expertise to enable us to reach a conclusion. We consider that this would need to be determined by a court on the basis of expert evidence commissioned for that purpose.
138. It is therefore not possible for the PPO to say whether the outcome might have been different if Nurse 2 had seen Ms B between 6.55pm and 7.15pm and called an ambulance. The post-mortem findings indicate that, given the absence of

ante-natal care and the problems with the umbilical cord and placenta, the outlook for Baby B was poor. However, Nurse 2 failed to fully assess Ms B's clinical situation, and, regardless of the outcome, this was a serious error of judgement. In this case, her failure removed any chance that Ms B would be taken to hospital in time to, at least, give birth in the presence of specialist staff and with appropriate pain relief, rather than in a prison toilet with no pain relief at all.

139. We were told that there was another incident earlier on the evening of 18 June in which another prisoner self-harmed and had to be taken out to hospital. It has been suggested to us that Nurse 2's involvement in this other incident affected her response to the calls she received about Ms B. We have not seen any evidence that this was the case and we note that Nurse 2 herself did not mention the other incident when we interviewed her and did not suggest in any way that the other incident had affected her response.

140. We recognise that Nurse 2's response on 18 June is a snapshot of her practice. At an early stage of the investigation, we were concerned that it could be indicative of her wider approach to care, and we recommended to her employer that they conduct a local review. The then Director of Nursing for Spectrum completed this review in November 2020 and concluded that this incident was not indicative of a serious deficiency in Nurse 2's practice. We have since had the opportunity to consider all of the evidence, including one of our previous investigations into the death of a woman at Styal in March 2019 in which Nurse 2 demonstrated similar unacceptable practice in terms of record keeping, recall of events and accurate handover, and we think further investigation of Nurse 2 is necessary. We make the following recommendation:

- **The Head of Healthcare and the Director of Nursing for Spectrum should:**
 - **review Nurse 2's clinical practice and consider whether she requires further training and professional support;**
 - **discuss the findings of this report with her personally; and**
 - **consider whether her actions on 18 June 2020 are a matter for local resolution or if they represent a pattern which would require discussion with the Nursing and Midwifery Council.**
- **The Head of Healthcare and the Director of Nursing for Spectrum should ensure that:**
 - **requests from officers for nurses to attend women are always recorded on the clinical record;**
 - **nurses consult the clinical record when triaging calls from officers; and**
 - **all relevant information is handed over at shift changes.**

The emergency response

Overall

141. None of the staff involved in the emergency response were aware that they were attending a maternity emergency until Ms B entered the second stage of labour (when the mother begins pushing the baby down the birth canal). Nevertheless, we note that Nurse 4 attended promptly when contacted by Officer N, in order to properly assess Ms B. The clinical reviewer concluded that Nurse 4 and the healthcare assistant applied their basic training and life skills well to cope with an event for which they had no specialist training or experience. Nurse 4 also acted promptly and effectively to look after Ms B's physical condition post-delivery.
142. CCTV showed the emotional shock and distress experienced by the staff involved on 18 June. This was also apparent during their interviews for this investigation. We are aware that some are receiving ongoing support as a result of their experience that night. We consider that all staff that tried to help Ms B and Baby B during the delivery, acted with humanity and to the best of their abilities.
143. Baby B showed signs that are unequivocally associated with death and we are satisfied that the decision not to attempt resuscitation was in accordance with wider Resuscitation Council guidelines.

Communications failure

144. There is no specific emergency code for a maternity emergency, but Nurse 4 radioed a code blue to indicate a person not breathing and we think this was appropriate in the circumstances. Prison guidance requires the communications officer to call for an ambulance as soon as a code blue is received. The failure of the communications system shortly after 9.06pm meant that the officer in the control room received neither Nurse 4's nor Officer N's code blue calls.
145. We have estimated that the system failure led to a delay of about four minutes before the communications officer rang for an ambulance, but he was unaware of what had happened and unable to give accurate information to the call-handler. Staff at the scene on Davies House were unaware they could not be heard in the control room. They clearly used the radio system after the first calls to reinforce that they needed an ambulance urgently because staff near the control room prompted the communications officer to call the emergency services a second time.
146. There was a further, more significant, delay of some 13 minutes before the ambulance service received the necessary information from Officer O to properly prioritise the emergency. While it was a significant delay and contributed another layer of stress and distress for all concerned, we cannot say that it affected the outcome for Baby B.
147. With hindsight it would have been sensible for someone on Davies House to be in direct communication by telephone with the control room to properly convey the nature of the emergency. This is something we have recommended in other cases when the communications officer, who is always at a distance from the

scene, does not have enough information to allow accurate triage by the emergency services.

148. We asked the prison whether they had experienced the same issue with the communications system before or since 18 June. We were told that it was a singular occurrence and therefore we make no recommendation about this.

Maternity emergency response in prison

149. The unexpected birth of a baby in a prison must be regarded as a serious medical emergency requiring immediate specialist help. The details of the baby must be clearly conveyed to the ambulance service and the staff role limited to keeping the baby warm and delivering rescue breaths or other action as instructed by a more expert provider such as the ambulance service or hospital.
150. This is the second unexpected birth in a prison that we have investigated since September 2019. Although we believe these events are rare, we consider there is a need for national guidance to all staff in women's prisons on what to do in the event of an unexpected birth. We recommend:

The Head of HMPPS Women's Team, in conjunction with NHS England, should provide guidance for all staff in women's prisons on what to do in the event of an unexpected birth. This should emphasise the need to obtain a rapid response from the ambulance service to guide staff through rescue breaths and keeping the baby warm.

Recognition of early labour

151. Prison nurses are not midwives, however we consider that it is sensible for nurses in women's prisons to receive training in recognising the signs of early labour to ensure that there is always someone on duty with this expertise. We recommend:

The Director of Health and Justice for NHS England should ensure that nurses in women's prisons receive training in recognising the signs of early labour.

Clinical care for Ms B

152. The clinical reviewer concluded that the healthcare provided to Ms B prior to 18 June was equivalent to the care she could have expected in the wider community. The postnatal care provided to Ms B was multi-professional, coordinated, met professional guidelines and demonstrated effective trauma informed care.
153. The clinical reviewer concluded that it was not possible to form a single overall judgement on the equivalence of Ms B's care on 18 June, given the exceptional nature of the event.
154. Our investigation found a lack of understanding and clinical experience of the mechanics and side effects of long-acting reversible contraceptives, specifically their effects on menstruation. In June 2020, there were 364 women in HMP Styal, most of whom were of child-bearing age. We consider that nurses in

women's prisons should have at least awareness of and, ideally, relevant expertise in reproductive health, including long-acting reversible contraception. We make the following recommendation:

The Head of Healthcare and the Director of Nursing for Spectrum should ensure that:

- **training is provided for nursing staff in reproductive health; including long-acting reversible contraception; and**
- **all nurses undertaking secondary healthcare screening should be able to demonstrate competence in basic reproductive health as defined in the Royal College of Nursing's sexual health education directory.**

Identifying denial of pregnancy in prison

155. Denial of pregnancy is the term used when a woman is unaware of, or unable to acknowledge, the existence of her pregnancy. The system for managing the healthcare of pregnant women in HMP Styal, as in all other environments, is predicated on awareness of the pregnancy. Given the nature of the issue and the high turnover of the female prison population, it is not possible to identify the extent to which denied pregnancy is an issue in prison. Denied pregnancy in the wider community is quite rare.
156. There are a variety of reasons why women in prison might not know they are pregnant or might deny pregnancy, including chaotic lives, substance misuse and mental illness. The outcome of a denied pregnancy carries a high risk to mother and baby and may be life-threatening to both. The provision of appropriate antenatal care is crucial to improving these outcomes and prisons also have a responsibility for safeguarding of the mother and baby. It is therefore important that prisons do all they can to identify pregnant women and that trauma-informed care is at the heart of their approach.
157. We do not think it would be acceptable to make it mandatory for all women in prison of childbearing age to have a pregnancy test if they have capacity to make a decision to refuse. However, we do consider that there is more that could be done to make pregnancy tests available and to explain the risks of not having one if there is any possibility that the woman might be pregnant.

The initial and secondary health assessments

158. The initial health assessment, rightly, prioritises immediate risks to the health and safety of prisoners on their first night in prison. Prisoners often arrive in prison during the evening after a long day at court. The majority of women received are at risk of withdrawal from alcohol or drugs and are often in very poor physical health. The priority of staff is to ensure they receive appropriate medication and increased monitoring if they are considered at risk of suicide or self-harm.
159. The initial assessment also rightly includes a question about whether the woman is pregnant and includes the offer of a pregnancy test. However, we do not consider it is either appropriate or trauma-informed for the initial health assessment to include a range of questions about menstrual history,

contraceptive history and sexual health. This sits more appropriately within the secondary assessment, which is undertaken within seven days of arrival in prison in less stressful circumstances.

160. However, at present the secondary health assessment template does not provide for an exploration of reproductive health even though it is an issue relevant to most of the female prison population. No further information about the menstrual cycle or contraceptive history is obtained and the offer of a pregnancy test is not repeated. The lack of built-in history taking and discussion in the screening process means valuable information captured in the initial screen might be lost and is a missed opportunity to identify denied pregnancy and other reproductive health conditions.
161. A question about menstrual history at Ms B's secondary health assessment on 3 March might have established that Ms B had last had a period in November 2019, and in turn prompted discussion and consideration of the reasons for this.
162. The initial and secondary assessment templates are almost the same for male and female prisoners and do not reflect the gender specific standards to improve health and well-being for women introduced by Public Health England (PHE). We recommend:

The Director of Health and Justice for NHS England should review the initial and secondary screening tools used in the women's estate and ensure that:

- **both templates reflect the gender specific standards introduced by Public Health England (PHE);**
- **all pre-menopausal women are offered a pregnancy test at both the initial and secondary health assessments;**
- **the secondary health assessment template should include provision for a detailed reproductive health and obstetric history to be taken and for a discussion about sexual health, menstrual history and contraceptive history; and**
- **staff should receive operational guidance on taking a trauma-informed approach to discussing this area of women's health.**

Further opportunity to offer pregnancy tests

163. The investigation found there is another potential opportunity for offering pregnancy tests, and so increasing the opportunities for identifying denied pregnancy, when clinicians prescribe medication. There are a number of medications where the effect on the foetus is uncertain. One of these is the anti-depressant mirtazapine, which was prescribed for Ms B. NICE guidance CG 90 (Depression in adults; recognition and management) advises that mirtazapine should be used with caution in pregnancy.
164. We consider that as a safety net, clinicians prescribing medication for women in prison should be required to explain the potential dangers and offer a pregnancy test to all women prescribed medication which is known to or may have an effect

on the foetus. We think this should be regarded as part of the risk assessment within the prison protocol for prescribing, even if the medication is a continuation of a prescription which was initiated before entry into prison. We recommend:

The Director of Health and Justice for NHS England should develop a system where a pregnancy test is routinely offered before a medication that is known to or has the potential to affect a foetus is prescribed or continued.

Learning lessons

165. We recommend:

The Governor and Head of Healthcare should share this report with the staff named in it and give them the opportunity to discuss it in a supportive environment.

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