"Totally inappropriate" care contributed to the death of Anna Claire Baker

The inquest into the death of Anna Claire Baker concluded on 17 November 2004 at Cheshire Coroner's Court in Warrington. The jury returned a narrative verdict which found that serious failings in virtually all aspects of Anna's care contributed to her death on 26 November 2002.

Importantly for the family, the inquest into Anna Baker's death was genuinely thorough and effective. HM Coroner Nicholas Rheinberg ensured that the pre-inquest stages were constructive, that the appropriate range of expert evidence was heard and that the interests of Anna's family – her mother – were at the forefront of the proceedings.

Anna Baker's death was the second in a series of 6 deaths in a 12 month period at HMP Styal. Following the sixth of these deaths, that of Julie Walsh on 12 August 2003, the Prisons Ombudsman Stephen Shaw, was asked by the Minister of Prisons Paul Goggins MP to undertake an investigation into Ms Walsh's and the other 5 deaths, to establish whether there were any "common issues of concern". This was an almost unprecedented intervention. The Ombudsman's report has been made available to family members but has not yet been made public.

Anna was remanded into the care of HMP Styal on 1 November 2002. She arrived with an open F2052SH after escort staff recorded that she had attempted to hang herself some two weeks previously.

At the time of her remand, Anna was on a methadone maintenance programme prescribed by her local Community Drugs Team. She gave reception staff at HMP Styal this information and was offered a 'detox'. At that time HMP Styal's opiate withdrawal detoxification programme consisted of a fixed and reducing dosage of dihydrocodeine. Dihydrocodeine is essentially a painkiller and is not licensed for use in withdrawal programmes. No attempt was made to establish what treatment Anna had been offered in the community.

- The jury found that the inadequacy of this initial assessment contributed to Anna's death.

A great deal of concern was expressed at the inquest as to the suitability and adequacy of the detoxification regime offered to Anna Baker. HM Chief Inspector of Prisons had published a critical report in February 2002 in which her main recommendation was that a detoxification regime be introduced at HMP Styal. Her further report of January 2004 was even more critical of the prison's failure to act on this recommendation: she went so far as to directly link the deaths of 6 women prisoners in the meantime, including Anna Baker, to that failure. At the inquest it also became apparent that at the time of Anna Baker's death, HMP Styal had failed to put in place a "written and observed" detoxification policy, a mandatory requirement of PSO 3350.

On 7 November 2002 Anna's cellmate reported that she had tried to hang herself in their cell. Anna was placed in a 'safer cell' for the night. At the inquest the Senior Officer with responsibility for the wing at the time appeared to doubt whether this attempted hanging was genuine, at one point going so far as to state that Anna Baker had been placed in a safer cell to "call her bluff".

This officer admitted to never having seen HMP Styal's local suicide awareness policy, or national guidance, and to having had no training in dealing with suicidal or self-harming inmates, or those suffering from drugs withdrawal. Other members of staff reported brief,

patchy or even no training in some or all of these areas.

- The jury considered that there appeared to be a "total lack of awareness and staff training in the management of persons at risk of self-harm and suicide."

Anna was returned to ordinary location on 8 November 2002. She was seen by a locum doctor that day who prematurely terminated the diyhydrocodeine detoxification because Anna had complained of side effects. This decision was criticised by the Coroner's expert Dr Louise Sells.

On 9 November 2002, the Senior Officer closed the F2052SH that had been opened for Anna on 1 November 2002, without the benefit of healthcare staff input as is required, and without questioning Anna about her state of mind and the recent suicide attempt.

Between 9 and 25 November 2002 various reports of volatile and unpredictable behaviour were recorded in respect of Anna.

- The jury found that Anna was probably withdrawing from drugs whilst at HMP Styal, and that this was the result of an "inappropriate and inadequate detoxification regime, exacerbated by a lack of staff, staff training, and funding". They considered these to be contributory factors in the death.

On 25 November 2002, the day before her death, Anna Baker was placed on the basic regime because of her unpredictable behaviour. This meant that she was confined to her cell for between 22 and 23 hours a day, her allowance was cut and her television was removed. The Senior Officer who had closed the F2052SH carried out a cell-share risk assessment and decided that she posed a high risk to any cell mate and should be placed in a single cell. Although this officer was aware of the suicide attempt on 7 November, she decided to place Anna alone, on basic regime, in a cell with a bunk bed.

Later on 25 November 2002, a second F2052SH was opened by another officer. HM Prison Service policy on cell-sharing risk assessments for prisoners on an open F2052SH was not followed. Two safer cells were apparently available.

Anna was seen by a doctor and a mental health nurse on the morning of 26 November 2002. The F2052SH did not accompany Anna so neither was aware that she posed a self-harm risk. Both said that they would have acted differently if they had known. Specifically, the doctor said that he would have tried to stop Anna being placed alone in a cell with a bunk bed.

- The jury were "extremely concerned" about the management of the F2052SH system, citing a lack of communication between staff and departments as a contributory factor in the death. They were concerned about the failure to refer to the earlier F2052SH and considered the decision to place Anna alone in a cell with a bunk bed to have been "totally inappropriate".

Anna was recorded as returning to her cell at 12.00 on 26 November 2002. She was given lunch and a letter from her boyfriend, which turned out to be distressing. At 13.50 the officer who came to collect her tray found Anna hanging from the top bunk by a ligature made of strips of towel. An ambulance was called and attempts made at resuscitation. This was not successful however and Anna was pronounced dead in her cell at 14.25. She was 29.