Bhatt Murphy Solicitors

PRESS RELEASE

Three years since the death of Baby Brooke Leigh Powell at HMP Styal on 18 June 2020

Sunday 18th June 2023 marks three years since Baby Brooke passed. Her mother Louise Powell has lived with the agony and trauma of that loss for three years. She remains looking for answers and explanations from the Ministry of Justice and healthcare about what happened.

Louise Powell said:

"When she was born, Brooke was perfect, her skin was perfect. I believe that she died in the process of labour. I believe that if someone had taken me seriously and listened to me, I would have been taken to hospital and my baby would be here today.

I was crying and begging for an ambulance but they did not get me one. I believe that the staff had listened to me and I had been seen by healthcare they would have immediately recognised that I needed urgent medical help and I was in labour.

I want justice for Brooke and for her story to be told. I have not been the same since Brooke was born. My life has been turned upside down. It's traumatising for me every day that things could have been different if someone listened to me and took me seriously, but nobody tried to help me. My life will never be the same because of this."

Jane Ryan, solicitor for Louise Powell said:

"There were multiple missed opportunities to help baby Brooke and Louise. There was no system in place to recognise unexpected births at the time. The Ministry of Justice cannot wash their hands of the events by solely blaming healthcare. There were more than enough warning signs and Louise's pleas for an ambulance should have been listened to by staff, rather than leaving her to give birth in a prison toilet.

As we have seen with the appalling events in Bronzefield and Styal, prisons are not safe for pregnant women. The risk to life and of inhumane treatment is too high."

NOTES TO EDITORS

For further information please contact **Jane Ryan** at Bhatt Murphy j.ryan@bhattmurphy.co.uk

A PPO investigation concluded in January 2022.

The matter was referred to the PPO by the Secretary of State for Justice in 2020. The Terms of Reference provided that the PPO should investigate and report on the decisions, actions and circumstances surrounding the stillbirth of a baby at HMP Styal on 18 June 2020; review the clinical care provided to the baby's mother in

conjunction with NHS England & NHS Improvement; ensure as far as possible that the full facts were brought to light and any relevant failing was exposed, any commendable action or practice was identified, and any lessons from the death are made clear; provide explanations and insight for the baby's mother help fulfil the investigative obligation arising under Article 2 of the European Convention on Human Rights; and make any appropriate recommendations.

The investigation made several findings including:

- It was 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 Louise might have given birth in hospital with proper clinical support and medication instead of in a prison toilet with untrained staff;
- 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;
- There were missed opportunities to identify that Louise needed urgent clinical review during the evening of 18 June;
- Several officers thought the Louise was pregnant when they saw her during the evening of 18 June 2020 but accepted the Louise's assertions that she could not be;
- The nurse did not review Louise' record sufficiently or go to see her as she should have done;
- She failed to fully assess Louise's situation, and this was a serious error of judgement;
- Louise's symptoms might have indicated a variety of acute conditions and the failure to review her was a serious error of judgment;
- There was no guidance to staff on what to do in the event of an unexpected birth;
- There were 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.

Civil proceedings and an investigation by the Nursing and Midwifery Council remain ongoing.