

**Investigation into the death of a man
at HMP Risley in May 2008**

**Report by the Prisons and Probation Ombudsman
for England and Wales**

April 2009

This is the report of an investigation into the circumstances surrounding the death of a man. He was 41 years old when he was found collapsed in his cell at HMP Risley in May 2008. He was pronounced dead some 30 minutes later by paramedics. A post-mortem revealed that he had severe coronary artery disease and this had led to his death.

The man had struggled with substance misuse since his teens. After a two year period of being drug-free between 2005 and 2007, he returned to heavy drug use following difficulties in his relationship and the threat of losing his home. The man leaves three children and two step-children. Fellow prisoners and staff commented that his cell was full of pictures of his family, and that he spoke regularly to them on the telephone. I would like to offer my sincere condolences to his family for their sad loss.

The investigation was led by one of my investigators. One of my family liaison officers spoke to the man's partner on the telephone to tell her about my investigation and to ask whether she had any particular questions about his time in Risley. In addition, an independent review of his medical care was undertaken by the clinical reviewer on behalf of the local Primary Care Trust. I am grateful to the clinical reviewer for his assistance. I am also grateful to the prison's liaison officer and to the staff and prisoners at Risley for their co-operation.

The clinical reviewer has concluded that the care the man received in prison for his chest pain compared favourably with the treatment he would have received in the community. However, my report raises a number of issues about the prison's response to his collapse. I am pleased to record that Risley has already implemented policies to address some of these matters. I make four recommendations with the intention of further improving the prison's ability to respond to a first aid emergency.

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

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Prisons and Probation Ombudsman

April 2009

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SUMMARY

The man was aged 41 years when he died at HMP Risley in May 2008. He was found collapsed in his cell by another prisoner. Despite the efforts of staff to revive him, he was pronounced dead some 30 minutes later. A post-mortem revealed that he suffered from serious coronary artery disease which had led to his death.

The man had transferred to Risley on 24 January 2007. He was located on the re-integration unit and mixed well with his peers. He leaves a partner, three children and two step-children. He was in close contact with his partner and all of his children, and was waiting for a transfer to a prison closer to home so that he could see them more regularly.

On 27 April 2008, the man complained of chest pains and numbness in his left arm. He was taken to outside hospital but tests showed he had not had a heart attack and so he was returned to Risley. He was examined the following day by the prison doctor who referred him to an out-patient clinic at another hospital. His first appointment at this clinic was scheduled for 14 May.

A clinical review of the man's medical treatment while at Risley was undertaken by the clinical reviewer. The clinical reviewer concludes that the care the man received in prison for his chest pain compared favourably with the care he would have expected to receive in the community.

I highlight a number of issues about the prison's response to discovering the man collapsed in his cell. The radio of the officer who first entered his cell failed, and he was unable to use it to call for emergency assistance. The member of staff designated first emergency response did not immediately hear the emergency radio call. None of the discipline staff who responded to the alarm was trained in cardio-pulmonary resuscitation. Two of the masks in the emergency medical kitbag were defective, and the wrong leads were attached to the defibrillator making it unusable.

The clinical reviewer has advised that, given the extent of the man's heart disease, it is unlikely that any of this made a difference to his chances of survival. Nevertheless, I endorse the recommendations made by the clinical reviewer and make four of my own. I have been pleased to learn that Risley has already implemented new policies designed to improve their response to medical emergencies.

THE INVESTIGATION PROCESS

1. I was notified of the man's death in May 2008. The investigation was allocated to an investigator the same day. Notices were issued to staff and prisoners at Risley telling them that an investigation would be taking place, and inviting those who wished to see the investigator to make themselves known. The investigator wrote to the Coroner and to the local Primary Care Trust.
2. The investigator visited Risley on 16 May. He met the appointed liaison officer and interviewed a prisoner and friend of the man. The investigator collected copies of the man's prison record and copies of other records associated with his death. He visited the unit where the man lived and spoke informally to a number of staff there. The investigator returned to Risley on 13 July when he interviewed six members of staff.
3. A clinical review of the man's medical care was commissioned from the local Primary Care Trust (PCT). The review was undertaken by a clinical reviewer and it appeared in full as an annex to the draft report.
4. One of my family liaison officers spoke to the man's partner on the telephone. She explained the nature and purpose of my investigation and asked his partner if she had any questions about his treatment in Risley. His partner did not raise any specific concerns at that time. However, she expressed her shock as she had been talking to him on the phone a short time before representatives from Risley arrived at her home to tell her of his death. His partner was aware that he had experienced chest pains some two weeks prior to his death, but said he had not mentioned feeling unwell during their conversation on the day he died. I hope my report helps his family better understand what happened in the time leading up to his death.

HMP RISLEY

5. HMP Risley is a male category C training prison in Cheshire. It has an operational capacity of 1,085, and offers a variety of work, vocational training courses and a comprehensive education programme. It has 24 hour healthcare provision. Primary healthcare is provided by the local Primary Care Trust (PCT).
6. B1 re-integration unit, where the man was located, is a small residential unit for prisoners who have had problems in the mainstream prison population. The aim is to provide access to courses and activities for those prisoners who have been previously removed from the regime, so that they can progress to a normal residential unit.
7. Risley received an unannounced inspection by HM Chief Inspector of Prisons in April 2008. In her report she wrote that Risley was a jail that simply had to improve, particularly in respect of keeping prisoners occupied and improving how safe they felt. There were also shortfalls identified with respect to healthcare provision, but none that has direct implications to the man's care. Similarly, the prison's Independent Monitoring Board (IMB) in its annual report for 2008 mentioned concerns about mental health services for prisoners, but nothing that applied to the man's care. (The IMB is an independent, lay body. Each prison has an IMB appointed to consider the humane and just treatment of prisoners and the range and adequacy of programmes preparing them for release.)
8. Prior to the death of the man, there had been three previous deaths at HMP Risley since 2004 when I was given responsibility for investigating all deaths in prison custody. The circumstances of the man's death are different from those earlier investigations and none of my earlier recommendations has any bearing here.

THE EVENTS LEADING UP TO THE MAN'S DEATH

9. As noted, the man was transferred to Risley on 24 January 2008. On 8 February, he was transferred to C wing. On 28 February, he was found in possession of a mobile phone and later the same day asked staff if he could be moved to the care and separation unit (CSU – the segregation unit) for his own protection. He said he owed money to the prisoner who had supplied him with the phone and that he had been threatened. He was relocated to the CSU. He said he was keen to be transferred to a prison on Merseyside so he could keep in better contact with his family.
10. On 13 March, the man was moved to B1, the re-integration unit. He was reviewed every two weeks and it was recorded that he complied with the regime, was polite to staff and mixed well with his peers. He had been placed on the transfer list for a Merseyside prison. He hoped to go to HMP Altcourse so that he could attend their 'STOP' programme (Substance Treatment and Offending Programme - an offending behaviour course).
11. Shortly after midnight on 26 April, the man pressed his cell bell and complained of chest pains and numbness in his left arm. He was seen by healthcare staff who performed an Electro Cardiogram (ECG) test using a defibrillator. As a result, an ambulance was called and he was taken to North Cheshire Hospitals NHS Trust. He was given two Tnl tests (blood tests which determine if a patient has had a heart attack) that showed negative and was returned to Risley at 6.30pm on 27 April. The following day he was seen by the prison doctor who prescribed aspirin and referred him to hospital for a tread mill stress test to detect any undiagnosed coronary artery disease. His hospital appointment was scheduled for 14 May.
12. At about 2.55pm on an afternoon in May, two Officers noticed that the man and two other prisoners had set up a 'mini-gym' using overturned tables and chairs in one of the association rooms. Both Officers said in interview that they told the prisoners to stop what they were doing because the activity had not been risk-assessed and they were not being directly supervised. The first Officer said the prisoners stopped and went off to have a shower. He then spent some minutes ringing around to see if he could set up a gym session for the three prisoners. On finding out that it might be possible for them to attend the gym on a Friday afternoon, he went into the shower area and told the man and the other two prisoners. The Officer said that all three men seemed fine.
13. One of the prisoners exercising with the man at interview said that he was doing some press-ups and sit-ups with him and another prisoner when the Officer told them to stop. The prisoner said they stopped and went for a shower. He said he was talking to the Officer on the landing when the man came out of the shower and went into his cell. Not long afterwards he heard some noise, and looking into his cell he saw him collapsed on the floor. The prisoner called for help and officers came to the cell.
14. The second Officer said he was sitting at a desk about five yards from the man's cell when he heard a prisoner calling him. He said he tried to call for emergency

assistance but his radio battery was dead. The second Officer entered the man's cell and saw him lying on his left hand side convulsing. He said his face was blue and his arms were out in front of him. The man was breathing, but in a laboured way. The Officer tried to get a response from him but could not. He held the man's head and noticed that he had vomited and urinated. The Officer said he was not trained in cardio-pulmonary resuscitation and, because the man appeared to be breathing, he did not attempt any life support. He said that healthcare staff arrived within two or three minutes of the alarm being raised.

15. The first Officer said he heard a shout for help and went into the man's cell. He saw the second Officer trying to revive him and two prisoners moving furniture to create space. The Officer used his radio to call for emergency assistance.

RISLEY'S RESPONSE TO THE MAN'S DEATH

16. The control room log sheet shows that the call from B1 asking for emergency medical response (the person carrying the radio with call sign Hotel 1) was made at 3.15pm. The Deputy Head of Healthcare was Hotel 1 on that day. She said at interview that she was in a meeting in the Healthcare Centre and did not immediately hear the call. A Nurse was carrying the radio with call sign Hotel 2, which meant that she was to offer support to Hotel 1 in an emergency. She said at interview that she did not hear Hotel 1 respond to the call so she contacted the control room to say that she was responding. Hotel 1 heard Hotel 2's response and realised that she must have missed the call for Hotel 1. She said that she left her meeting and met Hotel 2 coming out of a treatment room. Hotel 2 was carrying two emergency bags. They did not know what type of emergency they were responding to, so Hotel 2 asked the Head of Healthcare to collect a defibrillator and follow them to B1. Hotel 2 and Hotel 1 went immediately to the scene of the emergency.
17. Hotel 2 said that when she arrived at the man's cell an officer told her that he was "navy blue". She immediately asked for oxygen and an ambulance to be called. Hotel 2 began mouth to mouth resuscitation using a Laerdal mask (a mask used for resuscitation with a one-way valve to prevent transfer of fluids). Hotel 1 checked for a pulse. When she found none she started chest compressions. Hotel 1 said she checked the man's eyes with her pen torch and found that his pupils were fixed and dilated. Head of Healthcare arrived with the defibrillator but the correct leads were missing and they were unable to use it. The prison doctor also arrived and inserted an airway into the man's mouth. The man was given oxygen using an Ambu-bag (a bag valve mask used to give air to a patient with breathing difficulties).
18. The paramedics arrived at the prison at 3.35pm. They went to the man's cell and attached their defibrillator to him. The machine showed a flat line indicating that there was no electrical activity in his heart. They confirmed that he had died at about 3.40pm.
19. All the relevant agencies were notified of the man's death in a timely manner. Staff told the other prisoners on the wing that he had died and arranged for a Listener (Listeners are trained by Samaritans to provide confidential emotional support to fellow prisoners in distress) to go to the wing later that same afternoon. The care team offered support to staff involved in responding to the man's death. All prisoners who were deemed to be at risk of self harm were checked. The same evening there was a meeting (known as a 'hot debrief') for the staff involved to discuss the response to finding him collapsed.
20. A Principal Officer was nominated Family Liaison Officer. He and the Roman Catholic Chaplain went to the home of the man's partner later that afternoon and broke the sad news of his death to her.
21. The Roman Catholic Chaplain attended the man's funeral and the prison sent a wreath. A service was also held for him at the prison. This was attended by his friends and fellow prisoners from B1.

ISSUES CONSIDERED DURING THE INVESTIGATION

The clinical care offered to the man at Risley

22. The clinical reviewer's clinical review at Annex 1 provides a comprehensive account and analysis of the man's clinical treatment at Risley. I draw the attention of the local PCT and the Governor and Head of Healthcare at Risley to his findings and comments. I discuss the main points from the review below. The clinical reviewer has made a number of recommendations which I endorse.
23. The clinical reviewer finds that the man's key health problems were identified during his reception medical screen at Risley. He comments that more clinically relevant information could have been ascertained about his smoking history. There was also an issue about whether he had suffered a heart attack previously. There was some indication (but no objective evidence) in his record that he had, but a direct question was not asked at the reception screen and the man did not volunteer the information. It should be noted that when he attended hospital on 27 April the consultant commented there was no convincing evidence that he was suffering from heart disease.
24. The clinical reviewer says that the man's mental health history was identified and recorded at screening and that his needs were met appropriately while at Risley. He judges that the man was attended to in a prompt and appropriate manner when he complained of chest pain. The prison doctor assessed him on his return to Risley and acted appropriately by referring him to the rapid access chest pain clinic at North Cheshire Hospitals NHS Trust. Unfortunately, he died before his appointment there.
25. The clinical reviewer concludes that, in respect of the man's heart disease, he received care which compares favourably with what he would have received had he been in the community.

The prison's response to finding the man collapsed in his cell

26. The first officer to enter the man's cell once the alarm had been raised by the prisoner was originally located in the office. The officer tried to use his radio to call for emergency assistance but the battery was dead. Fortunately, another officer arrived within seconds and was able to use his radio to call for assistance. It was explained at a post-incident de-brief that new batteries had been received by the prison but there were still some old batteries in circulation. In this case, I consider that the number of other staff on duty meant there was not an unacceptable delay in calling for emergency assistance and no impact on the attempts to revive the man. However, I am concerned that had the man been taken ill during the night, or at another time when fewer staff were on the wing, the unreliability of the radio battery might have had more serious consequences.

I recommend that the Governor of Risley reviews the status of the radio batteries in the establishment and satisfies himself that discipline staff and healthcare staff are equipped with effective radio batteries.

27. None of the discipline staff who went to the man's cell was trained to give cardio-pulmonary resuscitation (CPR). As a result, some minutes elapsed before healthcare staff began trying to revive him. A few more minutes elapsed before the defibrillator arrived. Unfortunately, it was found that the correct leads were absent and staff were unable to use the machine. The clinical reviewer has concluded that, because his pupils were already fixed and dilated and because of the serious nature of his coronary artery disease, neither of these circumstances played a part in his death. The issue of training staff in CPR was raised at the post-incident de-brief and it was agreed that it should be considered whether all principal and senior officers should receive basic CPR training.
28. I consider that this is a sensible way to proceed. At a time when prison budgets are restricted it is not practicable for me to recommend that all staff are trained in CPR. However, given that the first few minutes are crucial in any attempt to revive a person who has suffered cardiac arrest, it is imperative that a reasonable proportion of staff on duty at any one time (and all healthcare staff who are expected to take the role of emergency response) are trained in CPR.

I recommend that the Governor and the Healthcare Manager provide emergency first aid training for all healthcare staff who are required to act as emergency response nurses.

I also recommend that a sufficient number of discipline staff are trained to ensure that, at any one time, at least one member of staff on any wing can give emergency first aid.

29. The notes from the de-brief also suggest that, as well as the defibrillator being fitted with the incorrect leads, two of the masks in the emergency bag were faulty. I am pleased that Risley now has a protocol for checking all emergency equipment. The defibrillator is checked daily and all other emergency equipment is checked daily or weekly.
30. At interview, both Hotels 1 and 2 commented that they were unaware of the nature of the emergency that they were required to attend. This made it difficult for them to judge what equipment they needed to take with them. A code system was not in operation at Risley at the time of the man's death but I have been pleased to learn that one has since been implemented. This is the practice in most prisons and in my view should be the practice in all prisons. I draw this to the attention of Offender Health.
31. A Nurse was the designated emergency response nurse and carried the radio with call sign Hotel 1. At interview, she told my investigator that she was in a meeting when the call for Hotel 1 came across the radio and did not immediately hear it. She was not sure whether her radio was turned down or whether she simply did not hear the call. Another Nurse heard the call for Hotel 1 and responded in her capacity as Hotel 2. I do not believe that there was a serious delay in the healthcare response to the emergency call. However, it clearly does not make sense for the person tasked with responding first to emergencies to have their radio turned down. Although Hotel 1 could not say whether she had turned her radio down or not, I judge that this is a sufficiently important issue for

the Governor to remind those staff who are designated as emergency response of the importance of being able to hear their radios at all times.

I recommend that the Governor ensures that emergency response staff are aware of the importance of being able to hear their radios at all times.

32. I have been pleased to note that two members of staff from Risley travelled to the home of the man's next of kin to break the sad news of his death in person.
33. I am satisfied that, despite the difficulties with some of the equipment, staff made a sustained and committed attempt to revive the man after he was found collapsed.

RECOMMENDATIONS

1. I recommend that the Governor of Risley reviews the status of the radio batteries in the establishment and satisfies himself that discipline staff and healthcare staff are equipped with effective radio batteries.
2. I recommend that the Governor and the Healthcare Manager provide emergency first aid training for all healthcare staff who are required to act as emergency response nurses.
3. I also recommend that a sufficient number of discipline staff are trained to ensure that, at any one time, at least one member of staff on any wing can give emergency first aid.
4. I recommend that the Governor ensures that emergency response staff are aware of the importance of being able to hear their radios at all times.