

**Investigation into the circumstances surrounding the
death of a man at HMP Stafford,
on 24 May 2009**

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

May 2010

This is the report of an investigation into the death of a male prisoner at HMP Stafford . The man died at a local hospital on 24 May 2009, having collapsed in his cell a little under two hours previously. The cause of death was found to be myocardial infarction (heart attack) caused by ischaemic heart disease (a lack of oxygen to the heart muscle). I offer my sincere sympathy and condolences to his wife and daughter, and to all who have been affected by his loss.

The investigation was carried out by an Investigator from my office. An independent review of the man's medical care in prison was led by the clinical governance manager for the local Primary Care Trust. I am most grateful for her assistance. However, due to a delay receiving the clinical review, I am issuing this report later than I would have wished.

I would also like to thank the Governor and staff of the prison for their co-operation during the course of the investigation. My particular thanks go to the head of residence and safer custody, for his work in liaising with the investigator.

The man had several significant medical conditions when he entered prison in March 2008. Although there were some aspects where I consider that more could have been done, the care he received was, in general, equal to that which he would have received in the community. Other prisoners have alleged that prison staff did not go straight into the man's cell when he was taken ill. I have considered their allegations carefully and found no other evidence to support them. In the event, when the man had the heart attack he was already in the ambulance. The report makes six recommendations, including the submission that all prisoners with complex care needs should have a care plan to reflect their needs.

Jane Webb
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SUMMARY

The man was given an indeterminate sentence for public protection (IPP) on 13 March 2008, and arrived at HMP Birmingham the same day. He had several long standing health problems including angina and lung disease. Shortly before his imprisonment, he had undergone an operation to widen the arteries in his legs. He was also asthmatic and diabetic.

The man had several outstanding outpatient appointments for his medical conditions with consultants in his local area when he came into prison. It is standard prison practice for planned appointments to be cancelled and new appointments should be made. For security reasons, prisoners should not know the date when they are due to go out of the prison. He was not referred to hospitals in Birmingham as the intention was to transfer him to a prison near his home where he could have continuity of his medical care. After some delays a transfer to HMP Stafford went ahead on 11 July.

He settled in well at Stafford, and reportedly got on well with staff and fellow prisoners. He was seen every day by nursing staff when collecting his medication. However the clinical review panel notes that, despite his significant medical conditions, no care plan was written to reflect his health needs. The panel recommends that all patients with complex care needs should have a care plan.

Throughout his time at Stafford, the man attended a number of outpatient appointments at local hospitals. In most cases the nature and outcome of these appointments was not recorded in his medical record. I recommend that such information should be recorded and correspondence regarding the outcome sought from the relevant hospital.

In the early hours of 24 May 2009, he woke his cell mate and said he was having difficulty breathing. He was sick and, shortly afterwards, collapsed on the floor and complained of chest pains. The night staff were called to the man's cell and requested an emergency ambulance. At around 2.45am, whilst in the ambulance about to leave for hospital, the man suffered a heart attack. The paramedics attempted to revive him but he was pronounced dead at 3.32am, shortly after arriving at the hospital.

With the exception of the control room operator, all of the night staff at Stafford work permanent night shifts. None of them have up to date first aid or resuscitation training. There are no healthcare staff on duty overnight at the prison. In these circumstances, I recommend that the Governor provide training for all permanent night staff. I make one further recommendation regarding breaking the news of the man's death to his wife.

THE INVESTIGATION PROCESS

1. The investigation was opened on 27 May 2009, when the investigator, issued notices announcing the investigation to staff and prisoners. The notices included an invitation to anyone who wished to submit information relating to the investigation to come forward. One prisoner came forward as a result.
2. The investigator was given access to the man's prison files, including the medical record. He visited Stafford on 16 August, 4 September and 29 September, interviewing five members of staff and two prisoners during the course of the investigation.
3. A clinical review of the man's health care whilst he was in custody was led by the clinical governance manager of the local Primary Care Trust. The clinical reviewer accompanied the Investigator on 19 August, a visit which included an interview with a prison nurse.
4. The Ombudsman's senior family liaison officer telephoned the man's wife on 18 June, to inform her of the investigation and determine whether she had any issues she wished it to address. The man's wife praised the staff and prisoners at Stafford and explained that, even though her husband was being seen by three different consultants, he was always taken for his appointments. She gave particular thanks to the lead nurse on E wing (where he lived), and described her as "brilliant".

HMP STAFFORD

5. HMP Stafford was built on its present site in 1794. It currently has capacity to hold 741 category C prisoners across seven wings. The man lived in a ground floor cell on E wing which, together with F wing, form an area of the prison known as the Crescent. The Crescent is designated as accommodation for vulnerable prisoners (those who are separated from the majority of prisoners because of factors such as the type of offence committed).
6. Healthcare is provided by the local Primary Care Trust, who employ a healthcare manager, nurses and support staff. The two wings on the Crescent share a full time nurse who oversees the medical needs of prisoner-patients on the wings, including administering treatments and seeing patients on the wing throughout the day as necessary. There is no inpatient healthcare facility at Stafford and no nurses work in the prison overnight.
7. Stafford was last inspected by HM Chief Inspector of Prisons in June 2009. She found that Stafford was performing “reasonably well” in all areas. She also found that the “provision of health services had improved”, there was good access to primary care, and health services staff were aware of the needs of older prisoners.
8. In their annual report for 2008, the Independent Monitoring Board (a body of local people who independently monitor and report on the prison) reported several “positive effects” since the appointment of the new Governor, in 2006. However, they did suggest that “more resources should be made available in support of healthcare arrangements”.
9. This is the seventh death of a prisoner at Stafford since the Ombudsman began investigating all deaths in custody in England and Wales in April 2004. Four of the previous six deaths were due to natural causes. My most recent report, regarding the death of a man who died after refusing all food, commended staff at Stafford for the “exceptional care” they provided. A second investigation, in 2008, commended the response of staff following the collapse of a prisoner in his cell.

KEY FINDINGS

10. The man arrived at HMP Birmingham on 13 March 2008, having been sentenced earlier that day. At the time of his imprisonment, he suffered from a number of medical conditions. After a heart attack in November 2002, he continued to experience frequent angina attacks. He also suffered from Barratts disease (abnormal cells in the oesophagus, leading to an increased risk of oesophageal cancer), pleural thickening (hardening of the lining of the lung as a reaction to asbestos fibres in the lung) and asbestosis (damage to interior of the lung due to inhaled dust).
11. The man also had claudication (narrowing) of his femoral arteries (a large artery in the muscle of the thigh) in both legs. In February 2008, he had undergone surgery known as an angioplasty (a surgical procedure to repair and widen the artery) and had a stent (a plastic tube used to help keep the blood vessels open) inserted into his right leg. In addition, the man was asthmatic, suffered from arthritis and was diabetic.
12. As a result of his many health problems, the man took a number of different medications. These included aspirin (to thin the blood and prevent a heart attack), prednisolone (an anti-inflammatory used to control arthritis and asthma), atorvastatin (to reduce cholesterol and the risk of a heart attack), GTN spray (a spray used to relieve the pain of angina attacks), bisoprolol fumarate (to prevent heart failure), azathiopine (to treat arthritis), lisinopril (to treat high blood pressure) and lansoprazole (to prevent the stomach producing gastric acid). He also used a salbutamol inhaler for his asthma.
13. The Prisoner Escort Record (PER, a form used by all the agencies which transfer prisoners) identified the man's medical conditions, as outlined above. Shortly after his arrival at Birmingham, he was seen by a nurse for a reception health screen (a routine health screen for all new arrivals into prison). The nurse listed the man's medication and noted that he had reduced mobility. She referred him to a prison doctor immediately so that his medication could be prescribed.
14. The following day, the man's wife telephoned the prison to speak about her husband's health and outstanding hospital appointments. She was asked to write in with details of the appointments. His wife subsequently wrote to the healthcare department at Birmingham on 15 March. She explained that he was required to take a monthly blood test, on account of taking azathiopine for his arthritis. She went on to say that her husband's arthritis was quite widespread and he sometimes needed help dressing, but he tried to be as independent as possible. She also said her husband was waiting to receive a follow up appointment from the consultant who fitted his stent.
15. The man attended a well man clinic (a general health assessment for men) on 15 March. His medical history was recorded again and he was

given advice about accessing various services. It was also recorded that he was not fit enough to attend the gym.

16. Three days later he was reviewed by a prison doctor. The doctor telephoned the rheumatology department at the man's local hospital where he had previously received treatment. She was told that the man was last seen in December 2008 and required further follow up. He had missed two appointments and his next, scheduled for 27 March, had been cancelled. The doctor noted that there was a plan to transfer him to a prison closer to his home to enable continuity of his medical care.
17. On 18 April, the man missed an outpatient appointment at the department of respiratory medicine at another hospital local to his home. It is not clear if staff at Birmingham were aware of this appointment. A follow up letter was sent from the hospital to the man's home address to say that a further appointment would be arranged in three months time.
18. A decision was made in late May or early June (the exact date is not clear) not to transfer the man to any prison local to his home. This was noted as being for "security reasons", although no further information was provided. The prison doctor therefore wrote a referral to the City Hospital, Birmingham, on 6 June. In her referral, she noted that the man's follow up appointment following the insertion of his stent was "long overdue". She went on to say that "delays in attempting transfer have resulted in a complete failure of follow up for his numerous problems".
19. The referral was not sent, however, as the decision not to transfer the man to Stafford was reversed. This decision was made by the head of residence at Birmingham, so that he could continue to attend appointments at hospitals in his local area. A transfer was arranged for 16 June, but was cancelled at short notice as there were no places available on the Crescent.
20. The transfer eventually went ahead on 11 July. A reception health screen was carried out by a staff nurse shortly after the man's arrival to Stafford. His medical history and ongoing conditions were noted, and he was allocated a ground floor cell on E wing.
21. Three days later, the man attended a review with a prison doctor. He said that his claudication was worsening and the doctor therefore referred him to a local consultant for a peripheral arterial assessment (peripheral arterial disease is the narrowing of the arteries in the legs). The prison doctor also referred him to a rheumatology specialist (who treats conditions affecting the joints and surrounding tissue) and a chest specialist.
22. He reportedly settled in well on E wing, where he was described as being "polite and no problem". On 18 August, a local community nurse whose care the man had been under before he was imprisoned, telephoned the healthcare centre. She requested that blood tests be taken monthly and

the results faxed to her. The first test was taken the following day, with the results faxed to the community nurse on 28 August.

23. On 1 September, the man went to an outpatient appointment at a hospital. There are no details recorded in his medical record as to the nature of this appointment. He attended another appointment on 24 September, at a local hospital. He underwent a scan of his legs to determine the level of blood flow through the arteries. The results of the scan and any subsequent changes to his treatment are not recorded in the man's prison medical record.
24. At the end of October, he attended a review with a prison doctor. He told the doctor that he had felt angina pains two days previously and was experiencing chest pain at night. The doctor requested that a new appointment be made with a chest specialist, which was subsequently made for 5 January 2009. The prison doctor also prescribed a course of tramadol (a painkiller) for the man's chest pain, and advised him to stop smoking. As tramadol is a controlled drug (meaning that it has high potential to be misused), prisoners have to collect it every day and take the medicine in front of the dispensing nurse. He kept all of his other medication in his cell and was given a 28 day supply at a time.
25. A rheumatology nurse visited Stafford on 16 December to assess the man. It emerged that he had not been taking some of his medication as instructed. He was advised and encouraged to do so. Despite these problems with his medication, the nurse told healthcare staff that she was happy with his progress.
26. The man had a family visit booked for 5 January 2009, the day of his appointment with the chest specialist. He therefore decided not to attend hospital. A second appointment was booked for 16 February. Although he attended this appointment, there is no record of the outcome in the man's medical notes other than a request for blood results to be sent to the local hospital.
27. Two days after the appointment, on 18 February, a nurse was called to E wing at around 11.30am to see the man who had said that he felt breathless. All prisoners had been asked to go to their cells so that the roll (the number of prisoners held in the establishment) could be counted and confirmed. As such, he had to hurry back to his cell without resting as he normally would. The nurse took his pulse, oxygen saturation level (a measure of the amount of oxygen in the blood) and blood pressure, all of which were within normal levels. She told the investigator that he recovered after five or ten minutes and, as a result, she did not think it was necessary for him to see a prison doctor.
28. On 27 February, he went to an outpatient appointment at a local hospital. Again, no information is recorded as to the nature of this appointment. However, at an appointment with a prison doctor three days later it was

noted that he had recently seen a rheumatologist. The man told the doctor that he was still smoking and was again advised to stop.

29. He next saw the prison doctor on 23 March, having made an application for an appointment one week earlier. He told the doctor that he had experienced pain in his abdomen when lying down for around a month. He added that he had been taking ibuprofen for the pain but it did not help. The doctor asked for a referral to be made to a gastroenterologist (stomach specialist).
30. At around 3.10pm on 6 April, he was taken ill with chest pain in the visits hall. He was brought to healthcare and seen by a nurse, who noted that he was very pale. He had not taken his GTN spray to the visits hall with him and was given one by the nurse. After five minutes, he said that he felt much better. The nurse told the investigator that this was an angina attack and she advised him to carry his GTN spray with him in future so that he could use it when he started to feel pain.
31. Ten days later, he saw the prison doctor for a review. He told the doctor he had experienced back pain for several years and sometimes had “spasms” in his back. The man also said that he was still getting pain in his chest, and in his abdomen when lying down. The prison doctor examined him and heard creps (crackling noises) in his chest. He prescribed a course of amoxicillin (an antibiotic).
32. The man attended outpatient appointments on 30 April and 18 May. Again, no information is recorded in his medical record as to the nature or outcome of these appointments. The man’s wife later told the Ombudsman’s senior family liaison officer that her husband was very upset as he had been told at hospital on 18 May that he might have to have a leg amputated.
33. On the evening of 23 May, the man played pool with his neighbour who lived in the cell next door to him (Prisoner A). Prisoner A told the investigator that the man seemed well that evening and he was not concerned about him. He remembered that they had to move the pool table to get it into the right position, which the man was able to do without any problem.
34. As usual, at around 7.30pm, the prisoners were locked in their cells for the night. During the night at Stafford, a Senior Officer (SO) is in charge of the prison, with the title ‘night orderly officer’. Along with three officers, he patrols the prison at night and responds to emergencies. Senior Officer A took this role on the night of 23-24 May 2009. In addition, an operational support grade (OSG, the grade below a prison officer) is stationed on each wing overnight. On this occasion Operational Support Grade A was working on E wing and he carried a radio which he could use to contact colleagues. The OSG also carries a cell key in a sealed pouch, which they may only open in an emergency. An unsealed key is carried by the

night orderly officer, who would normally be called should the OSG feel that he may need to open a cell.

35. Operational Support Grade A's shift started at 8.30pm and, as is standard practice, he carried out a roll check straight away. He told the investigator that he did not recall having any cause for concern about him at this time. The man's cell mate, Prisoner B, told the investigator that they played cards and dominoes together until around midnight. He recalled that the man seemed "fine" at this time. At around 1.30am, the man woke Prisoner B and said that he "could not breathe". The man was still fully dressed and was sitting in a chair. He got up to use the toilet but collapsed on the floor and was sick. Prisoner B told the investigator he tried to pick the man up off the floor but was unable to do so. He therefore sat him up against a chair. Prisoner B asked the man if he would like him to call for assistance, but he said that he was "fine".
36. Shortly afterwards, the man turned "yellow". Prisoner B therefore pressed the cell bell to call for assistance. The cell bell records for the night are unavailable due to a computer fault so it is not certain what time the cell bell was pressed. Operational Support Grade A, who responded to the bell, thought it was around 1.35am. Prisoner A, who was awake in the cell next door, thought it was around 1.50am.
37. On his arrival at the cell, Operational Support Grade A was told by Prisoner B that the man was suffering chest pains and had been sick. Operational Support Grade A then returned to the wing office to telephone the control room and ask for the Night Orderly Officer (Senior Officer A) and colleagues to assist him. The control room log records this telephone call as being made at 1.54am.
38. Whilst Operational Support Grade A was in the wing office, the man was sick for a second time and collapsed on the floor. Prisoner B again pressed the cell bell for assistance. Operational Support Grade A returned to the cell and recalled that the man's condition had changed "dramatically". He was now collapsed on the floor and in a lot of pain. Operational Support Grade A therefore used his radio to again call for assistance. The control room log records this call as being made at 1.57am.
39. Within a minute, Senior Officer A arrived at the cell along with two fellow officers. Senior Officer A told the investigator that he opened the cell and went in with his colleagues. He described the man as "lying on his back completely flat, complaining of chest pains". The Senior Officer asked the officers to pick the man up and sit him against a locker door. In contrast, Prisoner B told the investigator that, although the cell door was unlocked, none of the officers went inside the cell and he had to look after him on his own. Prisoner A, who was watching through the crack in his cell door, also said that none of the staff entered the cell.

40. Once the man was sitting up, Senior Officer A used his radio to contact the control room and asked for an ambulance to be called. This radio call is recorded in the control room log as having been made at 1.58am. A lone paramedic arrived at the prison at 2.09am and was escorted to the cell by a fellow Officer. The Senior Officer A recalled that the man's condition did not change in this time, although he was talking to the staff and said that he was in pain.
41. The man's condition remained stable during the time that the paramedic was present. At 2.35am, an ambulance arrived and he was taken to the ambulance by stretcher. At 2.44am, whilst in the ambulance, he suffered a heart attack. The paramedics immediately started cardio-pulmonary resuscitation (CPR). The ambulance left the prison at 3.09am, arriving at a local Hospital shortly afterwards. The hospital resuscitation team continued to work on him, but were unsuccessful. He was pronounced dead at 3.32am. A post mortem later established the cause of death as myocardial infarction (heart attack) caused by ischaemic heart disease (a lack of oxygen to the heart muscle).
42. The police were asked by the prison to break the news of the man's death to his wife, and visited her on the morning of 24 May. The wife and her son visited the prison later that afternoon, and met the duty governor, and a nurse who knew the man well. The funeral was held on 5 June, and the investigator found that the prison's contribution to the funeral costs was in accordance with PSO 2710 (the Prison Service Order that sets out the actions to be taken following a death in custody).

ISSUES

Cancelled appointments following reception to HMP Birmingham

43. The clinical review panel finds that the man received medical care in prison that was “comparable with care he would have received in the community”. However, they note that the man’s outstanding hospital appointments were cancelled when he first came into prison. It is standard practice throughout the Prison Service to reschedule any outstanding hospital appointments when a prisoner is received into custody. This is for reasons of security, as a prisoner is not permitted to know in advance of any time when he will be outside of the prison.
44. Although initially imprisoned in HMP Birmingham, he was not referred to a local hospital by Birmingham’s healthcare department. From his first days at Birmingham, it was planned to transfer him to a prison closer to his home so that he could continue to be seen by the consultants who knew him and hence ensure continuity of care. A transfer to Stafford was arranged for 16 June 2008, three months after the man’s arrival at Birmingham. However, this transfer had to be cancelled as there were no places available in the Crescent wing for vulnerable prisoners. The transfer eventually went ahead on 11 July. He was referred to a local hospital three days after his arrival at Stafford.
45. The clinical review panel makes the following comment:

“These cancellations resulted in delays in the man’s treatment and the ongoing management of his care. The medical reviewers in this case thought this would not have contributed to the man’s death.”

I make no recommendation concerning the continuity of healthcare by staff at HMP Birmingham but will draw my report to the attention of the Governor.

Care plans

46. The clinical review panel comments that “it is not clear if there was a care plan and a co-ordinated approach to the man’s care in either prison”. There was no care plan in the man’s notes. The deputy healthcare manager at Stafford told the clinical reviewer that if there was no care plan in the notes then “it can be assumed he did not have one”.
47. The man had several significant medical conditions. Although he was seen every day by nursing staff when he collected his tramadol, and was apparently well known to nurses who worked regularly on E wing, there were some periods during his time at Stafford in which no entries were made in his medical record for several weeks. The clinical review panel makes the following comment:

“When a prisoner is seen by a consultant of any speciality, they should have an active care plan and a co-ordinated approach to care. Seeing a prisoner when dispensing medications does not constitute a review or health assessment, especially when anecdotal evidence suggests that during these periods time is limited and can be quite pressurised. Therefore it does not facilitate the opportunity to converse with prisoners about their needs. However, it could be argued the man was given the opportunity to request a further assessment.

“Healthcare staff should use a planned approach for prisoners with complex care needs. A care plan is essentially a contract between the patient and main carer. It sets out what interventions the healthcare staff will deliver and what the patient will do for themselves.”

48. The clinical review panel goes on to make the following recommendation:

The heads of healthcare at Birmingham and Stafford should ensure that all prisoners with complex care needs have a care plan to reflect all of their needs.

Record keeping

49. The man attended a number of outpatient appointments at local hospitals throughout his time at Stafford. In the majority of cases, there is no note as to the nature or outcome of the appointment in his medical record and no discharge letter from the hospital.

50. In addition, the clinical review panel makes the following comment about the standard of record keeping in the man’s medical record:

“Handwritten records in Stafford’s entries were dated but not signed clearly or legibly in some instances, which made the audit trail complex thus creating difficulties in determining when actions were taken.

“There should be consistent recording of any nursing or medical activity in the [prison medical record] as writing on letters and blood results does not give a chronological overview as these are located elsewhere in the prisoner’s records. Standards of record keeping must be adhered to at all times and it is therefore suggested that this is re-audited to ensure that the standards expected are both adhered to and maintained.”

51. In her report following her June 2009 inspection of Stafford, HM Chief Inspector of Prisons made the following comments about clinical record keeping at Stafford:

“The clinical records were very well managed ... Entries made on prisoners at Stafford were of high quality, contemporaneous and generally in line with good practice guidelines, although a few were difficult to read and did not include the staff’s designation. The head of

healthcare audited a sample of records every month and the primary care trust carried out an annual audit”

52. It is unfortunate that the man’s clinical records did not meet the high standards identified by the HM Chief Inspector of Prisons and I will send a copy of this report to her office. I make the following recommendation:

The head of healthcare should remind staff that the nature and outcome of outpatient appointments at outside hospital should be recorded in the patient’s medical record. In addition, discharge notes should be obtained from the hospital following each appointment.

The head of healthcare should audit a selection of medical records to ensure that the required standards are being met.

Timing of the man’s collapse on 24 May 2009

53. There are some discrepancies in the times given by the staff and prisoners present when the man was taken ill. As such, it is not clear how long passed between Operational Support Grade A being called to the man’s cell and when he requested assistance from his colleagues. Unfortunately the cell bell records are unavailable due to an apparent computer fault. The timing of the telephone and radio calls are recorded in the control room log and reproduced in the table below:

Time	Event
1.54am	Operational Support Grade A on E wing reports (via the telephone) he has chest pains. Oscar One (the call sign for Senior Officer A) informed.
1.57am	Urgent message from Operational Support Grade A (via the radio) – prisoner collapsed on floor.
1.58am	Called ambulance 999 (at the request of Senior Officer A).
2.09am	Paramedics arrive at prison.
2.35am	Ambulance arrives at prison.
3.09am	Ambulance leaves with the man and two Officers.

54. The man’s cell mate, Prisoner B, told the investigator that the man woke him at around 1.30am when he felt ill (although Prisoner B also recalled that the paramedic arrived at 1.50am, as opposed to 2.09am as recorded in the log). Operational Support Grade A thought he responded to the cell bell at 1.35am and “immediately” went to telephone for assistance, a call that is recorded as taking place at 1.54am. In contrast Prisoner A, in the cell next door, thought he heard the cell bell go off at 1.50am. In addition, Senior Officer A told the investigator that he was called to the cell at 1.40am and requested an ambulance at 1.47am (in contrast to those times recorded in the log).
55. It is perhaps inevitable that there are discrepancies in the accounts of staff and prisoners regarding the time of events in circumstances such as

these. As the cell bell records are unavailable, I am unable to say whether there was a delay in Operational Support Grade A being called to the man's cell and urgent medical assistance being requested. Although the man was taken ill sometime before 2.00am, his heart attack did not occur until 2.44am by which time he was already in the ambulance and in the care of its crew.

Staff entering the man's cell

56. Prisoner B told the investigator that there were four members of staff present when the cell door was opened, but none of them entered the cell. He said that he therefore had to look after the man himself. Prisoner A, who lived in the cell next door, said he had been watching through a crack in his door and also told the investigator that none of the staff entered the man's cell. Prisoner A also said that he heard staff openly discussing the man's offence and sentence length whilst waiting for the ambulance to arrive.
57. Senior Officer A told the investigator that three members of staff went into the man's cell when the door was opened. He remembered the man was lying on the floor at the time. Senior Officer A said he asked two of his colleagues to sit the man up against a locker and pull his legs up, as he thought this would be the most comfortable position if he was having chest pains. The staff (other than one Officer who went to meet the paramedic) stayed in the "area of the cell" after this. Senior Officer A said he was unaware of any staff discussing the man's offence or sentence length.
58. Operational Support Grade A said the staff went into the man's cell when Senior Officer A opened the door. They examined the man and tried to make him as comfortable as possible whilst awaiting the arrival of the ambulance. Operational Support Grade A also said he was unaware of staff openly discussing the man's offence, although they may have discussed his risk in the wing office in preparation for the hospital escort.
59. It is clear that there is a significant discrepancy between the accounts of staff and prisoners as to whether the staff who responded to the man's collapse entered his cell. I am unable to say for certain which accounts are correct. Needless to say, however, I would be extremely disappointed if it were the case that staff did not respond appropriately when a prisoner was taken seriously ill. The Governor will wish to consider whether any further enquiries should be made.

First aid training

60. Senior Officer A is a permanent night orderly officer at the prison and has worked alternate weeks for around six years. The Operational Support Grades are also permanent night staff, and the officers work a 12 month period of nights before reverting back to day shifts. Senior Officer A was a first aid trainer for 11 years before joining the Prison Service, but told the investigator that his first aid training expired around 13 years ago.

Operational Support Grade A had worked for the Prison Service for around four years at the time of the man's death and was first aid trained (including CPR) in the army prior to this. He said that he had not had any first aid or CPR training since joining the Prison Service and his previous training would now be out of date. There is no first aid training available to the other night staff either.

61. The Ombudsman has observed in many previous investigation reports that speedy intervention by properly trained and qualified staff can be the difference between life and death. In the man's case, staff were not required to administer CPR as he did not suffer his heart attack until paramedics had arrived. However, were he to have stopped breathing prior to their arrival, he would have been cared for by untrained staff.
62. I think it is essential that discipline staff have the knowledge and confidence to carry out CPR and first aid effectively. This is especially the case at a prison like Stafford, where staff who work permanent nights do not enjoy the support of healthcare staff out of hours.

The Governor should provide training in first aid and cardio-pulmonary resuscitation for all staff who work permanent nights.

Breaking the news of the man's death to his next of kin

63. Prison Service Order (PSO) 2710, which provides instructions for the aftermath of a death in custody, says that Governors must:

“Arrange notification to the next-of-kin and any other person reasonably nominated by the prisoner as soon as possible in a suitable manner, giving an accurate factual account of what has happened.”
64. The accompanying Family Liaison Officer (FLO) Guidance recommends that:

“The family should be informed face to face as soon as possible after the death. Wherever possible this should be done by a dedicated Family Liaison Officer working alongside the Chaplain, or Governor or most senior individual available together with the Chaplain.

“The prison should demonstrate its duty of care and show that it is taking the death seriously by making a personal visit.”
65. The police were asked to break the news of the man's death to his wife. Her contact details were passed to the police at around 8.50am by the duty governor, and they visited the man's wife later that morning. The Governor told the investigator that the police broke the news to the man's wife “as a matter of course because they would want to make sure there are no suspicious circumstances because he shared a cell”. The Governor added that the prison was understaffed when the man died as two of the officers were out on his hospital escort.

66. The FLO Guidance says that the police may be asked to break the news of a death to the next of kin. However, this should be based on an assessment of factors such as the safety of staff and the likely level of hostility in the area to be visited. There is no suggestion that either factor was relevant in this case.
67. The man's wife lives around 15 miles from Stafford. Given that her husband died at around 3.30am, I do not think it would have been unreasonable to wait a few hours before visiting her, to avoid arriving in the middle of the night. However, my view is that this visit should have been made by prison staff. Such an approach would help to convey that a death in custody is a matter of proper concern to the establishment.

The Governor should ensure that, whenever reasonable, the news of a death in custody is broken to the next of kin by members of prison staff, face to face, in accordance with national instructions.

FAMILY RESPONSE TO THE DRAFT REPORT

68. I received a number of comments from the man's wife on the draft report, which I have discussed below. In general, his wife said she thought the care her husband received at Stafford was "very good" and she felt he got on well with most staff and prisoners.

Medical reviews following a hospital appointment

69. The man's wife suggested that prisoners' should be seen by a doctor or nurse following their return from an appointment at outside hospital. She suggested that such a review would allow staff to determine how the appointment went and to establish whether the prisoner needed clarification on the outcome or findings of the appointment.

70. The investigator discussed this comment with members of the clinical review panel. They make the following comment:

"In the community it is impractical and not always necessary to review a patient after each hospital appointment, although the patient can and should always be able to make an appointment to discuss any issues.

"The benefit of immediate review is often limited by lack of information if there is no communication from the hospital. Contacting the patient to make an appointment would be good practice if any change to treatment or care was advised by the hospital specialist."

71. The nature and outcome of the majority of the man's hospital appointments are not recorded in his medical record. It is not therefore possible to determine if any changes to his treatment were made by hospital specialists. Nevertheless, the healthcare manager should ensure that the assessments identified by the clinical review panel go ahead.

A review should be offered with a prison doctor if significant changes are made to a prisoner/patient's care or treatment by a hospital specialist.

Staff conduct following the man's collapse on 24 May 2009

72. The man's wife said she was "extremely distressed" to read Prisoner A's comments that staff were openly discussing her husband's offence and sentence length whilst waiting for the ambulance. She thought that talking about such personal information constituted "gross professional misconduct".

73. As I have noted previously, the Senior Officer A told the investigator he was unaware of staff discussing the man's offence or sentence length. He also said he was also unaware of this, but added that they might have discussed the man's risk in the wing office in preparation for the hospital escort.

74. An ambulance had been called for the man and it was very likely that he would be taken to hospital. Prison staff therefore had to determine the level of escort required (in terms of number of staff, use of restraints etc). A prisoner's offence and sentence length would be a factor in the consideration of these matters. Given the man's condition at the time, my judgement is that it would be better for staff to discuss these matters near the cell than to go to the office and leave him unattended.
75. However, officers should always remember that such information is sensitive and they should be guarded when discussing it. Due to the conflicting accounts I am unable to say whether staff did openly discuss the man's offence and sentence length. However, the Governor will wish to remind all staff to use caution when discussing details of a prisoner's case.

CONCLUSION

76. The man was an older prisoner with several long standing health problems. After initially being imprisoned at Birmingham in March 2008, he transferred to Stafford four months later. This enabled him to continue seeing the consultants who had been in charge of his care for several years. He was popular at Stafford and got on well with staff and fellow prisoners.
77. The clinical review panel finds that, in general, he received medical care comparable to that he would expect to receive in the community. However, there are some areas they consider could be improved. In particular, the panel recommends that patients with complex care needs should have an active care plan and co-ordinated approach to their care.
78. Despite his significant medical conditions, the man's death was unexpected. He suffered a heart attack in an ambulance on his way to hospital after being taken ill in the middle of the night. Although not required to administer CPR on this occasion, the investigation revealed that the night staff at Stafford do not have up to date first aid or resuscitation training. I recommend to the Governor that he seek to address this.

RECOMMENDATIONS

1. The heads of healthcare at Birmingham and Stafford should ensure that all prisoners with complex care needs have a care plan to reflect all of their needs.

Accepted – care plans will now form an integral part of the clinical IT system introduced last year and training is taking place in their use. These will then be implemented for patients with complex needs regarding long term illness.

2. The head of healthcare should remind staff that the nature and outcome of outpatient appointments at outside hospital should be recorded in the patient's medical record. In addition, discharge notes should be obtained from the hospital following each appointment.

Accepted – outpatients appointments will now be recorded automatically on the clinical IT system introduced last year.

3. The head of healthcare should audit a selection of medical records to ensure that the required standards are being met.

Accepted – a system of auditing electronic clinical records will be introduced in 2010.

4. The Governor should provide training in first aid and cardio-pulmonary resuscitation for all staff who work permanent nights.

Accepted – staff working on permanent nights will be prioritised for first aid training.

5. The Governor should ensure that, whenever reasonable, the news of a death in custody is broken to the next of kin by members of prison staff, face to face, in accordance with national instructions.

Accepted – this will be done in accordance with national instructions, whenever reasonable and following a risk assessment.

6. A review should be offered with a prison doctor if significant changes are made to a prisoner/patient's care or treatment by a hospital specialist.

Accepted – all staff to be made aware that patient returning from hospital with a change to care needs to be made an appointment to see the prison GP.