

**Investigation into the circumstances surrounding the
death of a man at HMP Buckley Hall
in June 2009**

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

November 2009

This is the report of an investigation into the death of a man who collapsed in his cell at HMP Buckley Hall in June 2009. I offer my condolences to the man's family, particularly his wife.

This investigation was undertaken by one of my senior investigators. Both he and I thank the Governor of Buckley Hall and his staff for their participation. I would particularly like to acknowledge the Principal Officer who acted as our liaison officer. The clinical reviewer was asked by the local Primary Care Trust (PCT) to undertake a review of the man's clinical care and I also greatly appreciate her assistance.

As is often the case in our investigations following a death from natural causes, I am strongly influenced by the findings of the clinical review. In the case of this man, the review finds that he largely received good care, and that his death could not have been anticipated. There are some recommendations in the review which may prove helpful should the prison face a similar sad situation in the future.

I myself make six recommendations. These largely relate to emergency procedures. However, even had they been in place beforehand, they would sadly not have prevented the man's death. I am pleased to learn that the Prison Service has all my recommendations.

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.

Stephen Shaw CBE
Prisons and Probation Ombudsman

November 2009

CONTENTS

Summary

The investigation process

HMP Buckley Hall

Key findings

Issues

Recommendations

SUMMARY

The man was a 49 year old man with no serious health problems. He had been in custody for some years and was a fairly heavy smoker.

During the early hours of a morning in June 2009, at HMP Buckley Hall, the prisoner in the next cell heard the man being sick. A short time later he heard a noise which sounded like someone falling and he alerted a member of staff. An OSG (officer support grade) attended and, unable to get a response from the man, called for assistance. The Night Orderly Officer, in charge of the prison at the time, made staff ready for the possibility that an emergency ambulance might be required to ensure any delays were kept to a minimum.

After a slight hold-up in accessing a cell key, staff entered the man's cell. It was immediately apparent that something was seriously wrong and an ambulance was summoned. An emergency medical equipment pack was available on the wing but was not brought to the cell. This was also the case for the resuscitation shields. Nevertheless, staff attempted to resuscitate the man until paramedics arrived a short time later. Having assessed him, they found that there was nothing they could do to revive him. Support was made available for staff and for prisoners.

Although the details of the man's next of kin held on prison records were out of date, the family liaison officer appointed by the prison was able to identify the man's wife's telephone number. He called her to confirm her identity and address and said that he needed to come and see her. She asked why, but he said he wanted to see her in person. He left the prison to make his way to her home.

In the meantime, the man's wife had become very concerned and telephoned the prison. She spoke to the duty governor, and at this stage he told her that the man had died. The family liaison officer was made aware of this conversation and continued his journey to see her in person. The man's wife later visited the prison.

There was some confusion over funds for the man's funeral and a collection that his fellow prisoners had held. This confusion was eventually resolved. There were also a few items of the man's property that were not found. Unfortunately, these remain missing.

I make six recommendations. These mostly concern the response to emergencies and provision of equipment to staff, although I also recommend that more support is given to the family liaison role.

THE INVESTIGATION PROCESS

1. HMP Buckley Hall provided my investigator with the man's core record including his medical records, as well as other relevant papers. He met with the Acting Governor and was shown around the prison, including the healthcare centre, the unit where the man lived, and his cell. He spoke to staff who had known him.
2. Notices were issued to staff and prisoners informing them of the investigation and inviting anyone with relevant information to contact our office. None was received. My investigator was given unrestricted access to the prison, staff, prisoners, and documentation relating to the man.
3. Prison officers and members of healthcare staff were formally interviewed and those interviews were recorded. The interviews were transcribed and interviewees invited to sign and return copies, confirming their accuracy. Although not all transcripts have been returned signed, they are attached as annexes to this report. My investigator wrote to the prisoner who had been in the next cell to the man (he had since been released from prison) asking if he could speak to him. No reply was received.
4. The local Primary Care Trust commissioned a clinical reviewer to conduct a clinical review of the man's care and treatment. The clinical reviewer visited Buckley Hall and conducted joint interviews of staff with my investigator.
5. A Family Liaison Officer from my office contacted the man's wife to explain our role and to offer her the opportunity to contribute to the investigation. My Family Liaison Officer and my investigator travelled to Manchester to meet the man's wife and brought away with them the following questions:
 - What was the cause of the man's death?
 - Was he looked after in prison?
 - A friend of the man had written to the man's wife and told her that the man's friends in prison had held a collection for him. They wanted to buy a piece of jewellery for the man and his wife's great-grandson and send flowers to the funeral. But when the friend had asked a prison officer to find out what had happened to the money, he was told that someone from the finance department had contacted the family and been told to give the money to charity. The man's wife said that no one had contacted her and asked what had happened to the money that had been collected.
 - The man's property did not contain some correspondence he had kept, or his wedding ring. The man's wife asked what had happened to these.
6. My investigator wrote to HM Coroner to inform him of the nature and scope of our investigation and to request a copy of the post mortem report. Upon completion, my report will be sent to the Coroner to assist his enquiries into the man's death.

HMP BUCKLEY HALL

7. Previously a closed female training prison, Buckley Hall was re-designated as a male category C establishment in late 2005. It consists of three units, with an operational capacity of 381 as of 9 February 2009. It holds sentenced prisoners mainly from the Manchester area.
8. Healthcare cover is provided by nurses from 8.00am to 8.30pm seven days per week. Doctors provide GP services for three hours per day Monday to Friday. Outside these times the local out-of-hours service provides medical cover when required.

Night State

9. Night state describes when the prison is locked up for the night and staffing levels are at a minimum. There is often just one member of staff per wing. Their role is to monitor the security of the wing and prisoners. Staff on the wings have radios to communicate with colleagues and the control room if they need to do so whilst they are away from a telephone. They only have a key to the cells in a sealed pouch. They will not open this except in the case of emergencies, and only when their safety and the prison's security are ensured. Staff on the wings do not carry keys to open the doors from the wing where they are based, and have to be unlocked from outside by a colleague.
10. The senior person on duty at night time is the Night Orderly Officer (the NOO). They are responsible for visiting wings to check on the welfare of the staff and ensure they are carrying out their duties correctly. The NOO will carry cell keys which are not in a sealed pouch. During night state it is not usual to unlock a cell unless the NOO deems it necessary and has sufficient resources to deal with the situation.

Previous deaths at Buckley Hall

11. Since I took over responsibility for investigating all deaths in prison custody, there has been one other death of a prisoner in Buckley Hall. This was in June 2004 when the prison was still a women's prison.
12. In my report on that occasion, I commented that communication with the family after the death had not been well managed. Things were better this time, but assisting bereaved families can be very difficult and I hope that the prison remains keen to improve should they find themselves in the unhappy position of having to inform another family of the death of a loved one.

Her Majesty's Inspectorate of Prisons' report

13. The last report published on Buckley Hall by HM Chief Inspector of Prisons followed an announced inspection from 30 April to 4 May 2007. The report found Buckley Hall to be an essentially safe and decent prison. None of the issues raised in the report is relevant to the circumstances of the man's death.

Independent Monitoring Board (IMB) report

14. Each prison in England and Wales has an Independent Monitoring Board responsible for monitoring day-to-day life in the prison and to ensure that proper standards of care and decency are maintained. The last report published by the IMB for Buckley Hall covered the period 1 July 2007 to 30 June 2008. There are no issues raised in the report which need to be detailed here.

KEY FINDINGS

15. The man was convicted in July 2002 and one month later was sentenced to seven and a half years imprisonment. He moved through the prison system and spent time in various establishments largely without incident. However, in April 2006 he absconded from HMP Woodhill. He was received back into HMP High Down in July 2006. He again moved through further prisons and arrived in HMP Buckley Hall in December 2008.
16. The man was a heavy smoker and had made unsuccessful attempts to stop smoking in 2004 and again in 2008. He had been prescribed inhalers to use in October 2002, but this ended in November 2003. Between November 2003 and September 2006, he reported shortness of breath twice and chest pain on three occasions. His chest was checked and found to be clear, and chest x-rays were normal. He had been assessed as requiring an operation to correct a hernia, but for administrative reasons the operation was cancelled on more than one occasion.
17. Like all prisoners arriving at Buckley Hall, the man was given a full primary care and mental health assessment: in his case by a nurse on 31 December. No problems were evident. In March 2009, the man was given a pre-operative assessment for his planned hernia operation and no problems were identified.
18. On the night of 1 June 2009, an Officer Support Grade (OSG) was on duty on B Wing. She commenced duty at 8.45pm, and at the handover from day staff there were no concerns about the man. The OSG said in interview that the night was fairly uneventful until approximately 5.30am when the prisoner in the cell next to the man activated his cell call bell. She went to the cell and the prisoner told her that he thought there was something wrong with the man. He said that at about 5.00am he had heard the man being sick, and he had now heard a thump from the cell.
19. The OSG looked through the observation panel of the man's cell and saw him lying on the floor, with his head partly under the bed. She knocked on the door and called to him a few times. She was unable to gain a response, although she thought she saw him move. Thinking he may have fainted, she returned to the office and telephoned the control room. She spoke to a second OSG and requested assistance, saying that she had an unresponsive prisoner.
20. As noted earlier, when the prison is in night state the officer in charge is the Night Orderly Officer (NOO). On 2 June, this was a Senior Officer (SO). When the OSG spoke to the second OSG, the NOO and an officer were also in the control room, along with a third OSG. On hearing that there was an unresponsive prisoner, the officer immediately made her way to B Wing. The NOO told the second OSG to obtain a radio and be prepared to go to the front gate in the event that someone needed to allow an ambulance into the prison. He told the third OSG to remain in the control room and be ready to open the vehicle gates between the main gate and B wing if an ambulance was

needed. The NOO then also left the control room to make his way to B Wing, leaving approximately a minute after the Officer.

21. Having made the telephone call, the OSG returned to the man's cell and once more tried to get a response from him. The prisoner in the next cell said that he had now not heard anything for some ten minutes. Being still unable to gain a response from the man, the OSG now became more concerned and put a call out over the radio for urgent assistance.
22. The layout of Buckley Hall means that the administrative block, including the control room, are at the bottom of a steep hill. The residential units are at the top of the hill, with a number of gates in between. The Officer and the NOO both had to make their way up this steep hill to get to B Wing. Knowing that the NOO was following behind her, the Officer left the pedestrian gates open as she unlocked them, the NOO locking them behind him as he went through. She arrived first and entered the unit, and with the OSG decided that they needed to break the seal on the OSG's key pouch and access the cell. However, they struggled to break the seal and before they had managed to do so, the NOO arrived. As the NOO, he was carrying a set of keys, so he unlocked the cell and he and the Officer went in.
23. The man was lying on his left side, partly under his bed, and there was a pool of vomit beside him. The NOO checked for a pulse and, being unable to find one, immediately contacted the control room through his radio and requested an emergency ambulance. He referred to the incident as a Code Blue, meaning that the patient was not breathing. The second OSG called for an ambulance at 5.35am.
24. The Officer and NOO pulled the man from being partially under the bed and turned him onto his back. The Officer could not detect a pulse or signs that he was breathing. In interview, the NOO told my investigator that he had formed the view that the man was already dead. He said that the Officer told him that she too had formed the same view, but would nevertheless attempt resuscitation. No emergency pack had been brought to the cell, and the Officer was unable to find a resuscitation shield to use for mouth-to-mouth. (The NOO mentioned in interview that staff do not carry anti-ligature knives either, although that was not a factor here.) Nevertheless, she proceeded to perform cardio-pulmonary resuscitation (CPR).
25. When he had requested the ambulance, the NOO had asked the third OSG to prepare for the ambulance's arrival. In order for a vehicle to get from outside the prison to the residential units, they must pass through two sets of electronic security gates at the prison's perimeter fence, then a further six gates on the route up the hill. The second OSG had gone to the gate lodge to allow the ambulance access through the outer security gates when it arrived. The third OSG made her way up the hill, unlocking and securing the gates open as she went. In the meantime, the NOO had asked the OSG to go and open the gates from the top of the hill. Once the third OSG and the OSG had secured all the gates open, the third OSG went to C Wing to relieve the second Officer so she could go and assist on B wing.

26. The ambulance arrived at 5.45am and was let through the security gates by the second OSG. It then had a clear path up to B Wing. The Officer continued to try to revive the man until paramedics arrived at the cell. They assessed the man but at 5.52am said that there was nothing they could do.
27. The OSG and the Officer were both visibly upset. The second Officer took them into the wing office, then went onto the wing to assist the paramedics with some of the man's details. However, as there were no medical staff on duty during the night, discipline staff were unable to access his medical records for reasons of patient confidentiality. The second Officer provided what details she had available to the paramedics, then escorted the ambulance down the hill and back out of the prison, closing and locking the series of security gates behind her.
28. The NOO put the contingency plans into operation and sealed the cell. He informed the duty governor what had happened. The duty governor made his way to the prison and arrived at approximately 6.45am and took control. He ensured that all staff arriving at the prison were made aware of what had happened, and ensured that support systems were available for staff and prisoners. There were no prisoners on B wing at that time who were on special measures because of any possible risk of self-harm, but all prisoners who had been recently taken off such measures were spoken to. (One prisoner was subsequently judged to need monitoring and was placed on special measures.) When the rest of the prison was unlocked to allow the prisoners to get their breakfast, B Wing remained locked. Staff delivered breakfast to prisoners in their cells, and explained why this was happening. They were later unlocked when it was time to attend work. Notices were issued to staff and prisoners informing them of the man's death.
29. A hot debrief (held as soon as possible after a death in custody to ensure that staff involved have an opportunity to discuss any issues arising) was held at 7.45am, chaired by the Governor. The problems with opening the sealed key pouch and with obtaining resuscitation shields were identified and raised as issues to be immediately resolved. The Officer Crook and the OSG were still shaken and the Governor reminded everyone that the care team was available. Bearing in mind that most of the staff who had been involved were ending a scheduled week of night shifts and would therefore be out of the prison for a week, the Governor reminded them that they could still seek support whilst not in the prison if necessary. A debrief for governor grades was held in the Governor's office at 10.30am.
30. A governor grade was appointed as Family Liaison Officer (FLO). The address and telephone number held on prison records for the man's next of kin were out of date, but the FLO obtained his wife's telephone number from his record on the prison telephone system. He telephoned the man's wife and asked her to identify herself. Once he had confirmed this he asked if anyone from prison had called her that morning and she said that they had not. He said he needed to speak to her urgently about the man and asked her to confirm her address. At this point the man's wife became concerned. She

told the FLO that she suffered with heart problems, and asked what he wanted to talk to her about. The FLO said he was leaving the prison and would be with her shortly. He ordered a taxi and asked the Senior Officer to accompany him. The chaplain contacted him and asked if she could also attend, which he agreed.

31. In the meantime, however, the man's wife had become seriously concerned and telephoned the prison. The duty governor spoke to her, and at this point he told her of the man's death. He let the FLO, who by this point was in a taxi, know that the man's wife was aware of her husband's death, and the FLO telephoned her to say he was on his way to her home.
32. When he arrived the FLO explained the inquest process to the man's wife. She asked about funeral arrangements, and the FLO said the Governor would discuss this with her. He agreed to arrange for her and her daughter to visit the prison, including seeing the man's cell. They subsequently did so.
33. A church service was held for the man in the prison and a large number of people attended. However, there was a delay in organising the man's funeral whilst his wife made financial arrangements, unaware that the prison would be willing to pay. Eventually the man's wife found funds for the funeral and it went ahead. Having confirmed that she had no objections, the FLO and the chaplain attended.
34. The man's wife received a letter from one of the man's friends in Buckley Hall. He told her that the man's fellow prisoners had held a collection to send flowers to the funeral, and to buy the man's great-grandson a piece of jewellery to remember his great-grandfather by. However, the man's wife had not received either of these. The man's friend had asked a member of prison staff what had happened to the money and been told that the member of staff would check with the finance department. He was subsequently told that someone had telephoned the family and they had asked for the money to be donated to charity.

Post mortem

35. The cause of death was given as:

- a. acute cardiac failure
 - i. due to or as a consequence of
- b. acute coronary artery thrombotic occlusion

In lay terms this is a heart attack due to a blocked artery.

ISSUES

36. The clinical reviewer notes that apart from his smoking the man did not appear to have any other significant risk factors to indicate that he might suffer from heart disease. His blood pressure was within the normal range and, when he was given an ECG test (electrocardiogram, a test of the heart) as a pre-operative test in March 2009, the results were normal.
37. The clinical reviewer is satisfied that the healthcare the man received was to the same level he could have expected in the community. The one exception to this is that a minor operation he was waiting for was postponed. The clinical reviewer makes a number of recommendations, some of which I expand upon below. I would bring both the Governor's and the Head of Healthcare's attention to the others, including those referring to the management of cardiac risk factors for prisoners over the age of 35, the availability of defibrillators, and the availability of first-aid trained staff.
38. In addition, the clinical reviewer identifies some areas of good practice. This covers policy issues including the attempts to help the man give up smoking and the protocol between the ambulance service and the prison. She also commends the actions of staff responding to the man's collapse, particularly the Officer and the NOO, and again I would draw the Governor's and the Head of Healthcare's attention to these.
39. Staff responded quickly and appropriately to the OSG's call for assistance. There was, though, an in-built delay due to the location of the control room at the bottom of the hill, while the wings are at the top of the hill. I appreciate that there are a number of operational issues the Governor needs to take into account, but I would recommend that he considers whether the control room is currently best-placed to allow staff to react to an emergency.

The Governor should consider whether the control room is best placed as things stand to allow staff to react to an emergency.

40. When the OSG and the Officer attempted to break the sealed pouch containing the cell key, they were unable to do so. This is worrying, and although it is unlikely that it made any difference in this case, it is obviously something that must be rectified. It was identified in the hot debrief, but I would nevertheless urge the Governor to ensure that the actions subsequently taken have addressed the problem. All staff must be familiar with sealed pouches and confident that in an emergency they would be able to open them.

The Governor should ensure that the action taken in relation to the difficulty in opening sealed key pouches has rectified the problem

41. When staff went to the man's cell, emergency medical packs were not brought with them. The clinical reviewer notes that it is unclear from procedures who should be responsible for bringing these and at what stage. In this instance it does not seem to have affected the outcome but it could do so in the future.

Once again, this issue was identified in the hot debrief and I suggest that the Governor and Head of Healthcare ensure that the action taken is effective, and that procedures will ensure that the emergency equipment is indeed available in an emergency.

The Governor and Head of Healthcare should ensure that it is clear who is responsible for taking medical packs to an emergency.

42. I am also concerned that, when staff entered the man's cell, they were unable to find a resuscitation shield to use when performing mouth-to-mouth. In this instance the Officer proceeded without a shield, but in other instances this may cause a delay in attempts at resuscitation. These are a small and inexpensive first-aid tool, and the Governor may wish to consider issuing all staff who have been trained in CPR with resuscitation shields to carry whilst on duty.

The Governor should consider issuing all CPR trained staff with resuscitation aids.

43. I note that staff are not issued with anti-ligature knives. Whilst not a direct feature of this investigation, this is both disappointing and dangerous. Prison Service Order (PSO) 2700 says at paragraph 11.3.3 "... uniformed staff in closed and semi-open establishments must be provided with and carry on duty their own personal issue cut-down tool ..."

The Governor should ensure that all staff are issued with anti-ligature knives in accordance with PSO 2700.

44. While treating the man, paramedics asked for his medical information. No medical staff were on duty at the time, so for reasons of medical confidentiality staff were unable to access his medical records. Although this may seem odd, if paramedics were called to an emergency outside of prison, they would similarly not have access to the patient's medical records.
45. The prison acted swiftly to inform the man's next of kin about his death, and the FLO used his initiative in obtaining the man's wife's telephone number when the official records were found to be out of date. However, in telephoning the man's wife to confirm her identity and address but not telling her why he wanted to come and speak to her, I regret to say he (doubtless inadvertently) caused her a good deal of uncertainty and stress. The FLO was right to want to inform the man's wife in person, but might have tried to clarify her whereabouts by other means and not left her in a state of uncertainty.
46. There was also some confusion over the collection made by the man's fellow prisoners, and the prison's willingness to pay for the funeral. When the man's wife found out that his fellow prisoners had held a collection for him, and the prison had apparently donated the money to charity on the family's instructions, she told my investigator that nobody had contacted her to ask this.

47. My investigator asked the prison to look into what had happened. He also asked about the issue of the funeral payment, and pointed out that some of the man's property had not been returned, including his wedding ring. As a result, the prison contacted his wife about the collection, which had not in fact been given to charity and was still there. The prison also agreed to reimburse her for the cost of the funeral. Unfortunately, they were still unable to locate the missing property, including the wedding ring. I note that there is guidance to Buckley Hall staff who act as family liaison officers, including references to the guidance available in PSO 2710. But the Governor may wish to ensure that staff have sufficient guidance for this important and sensitive role. It might be useful, for example, if families are given written confirmation of offers, such as assistance with funeral costs, which are often made verbally at times of great stress.

The Governor should consider what ongoing guidance and support is available for staff acting in the family liaison officer role.

CONCLUSION

48. The man was an apparently healthy man, apart from his smoking. His healthcare was well looked after in prison, despite the double cancellation of a minor operation (which he subsequently refused to have). When he collapsed in his cell during the night, staff responded quickly and professionally. None of the issues highlighted in this report is likely to have made any difference to the sad outcome on this occasion. Nevertheless, there are some learning points which may make a difference if the prison were to face a similar situation in the future.
49. This was obviously a very difficult time for the man's wife. The way in which she found out about her husband's death was not ideal, and she suffered further stress in trying to identify funds for her husband's funeral. Dealing with families at the death of a loved one is not something that can be prescriptive. Every bereaved person is an individual and what is right in one instance may not be right in another. In this case, the prison did seem to try hard to act correctly, and I am conscious that Buckley Hall is fortunate in not having much experience of dealing with deaths in custody. But some issues remained unresolved until raised by my investigator and family liaison officer, and again I hope that the prison can learn from this.

RECOMMENDATIONS

The Governor should consider whether the control room is best placed as things stand to allow staff to react to an emergency.

The Prison Service has accepted this recommendation, commenting:

“It is accepted that the physical geography of the prison and the historical practice of night staff congregating at the Control Room which causes significant response issues. The Control room will remain in its present location, and in future the Night Staff will be based on the ‘Top Compound’ during night states.”

The Governor should ensure that the action taken in relation to the difficulty in opening sealed key pouches has rectified the problem.

The Prison Service has accepted this recommendation, commenting:

“All sealed pouches will be inspected and replaced and re-sealed with ones that are easier to open.”

The Governor and Head of Healthcare should ensure that it is clear who is responsible for taking medical packs to an emergency.

The Prison Service has accepted this recommendation, commenting:

“An agreed set of instructions will be published to all staff, and the Control Room staff will be given an additional ‘Prompt’ to their emergency contingency plans to remind responding staff to collect the emergency pack.”

The Governor should consider issuing all CPR trained staff with resuscitation aids.

The Prison Service has accepted this recommendation, commenting:

“Individual Resuscitation equipment will be obtained and issued to those trained staff.”

The Governor should ensure that all staff are issued with anti-ligature knives in accordance with PSO 2700.

The Prison Service has accepted this recommendation, commenting:

“All staff to be trained and issued with cut-down tools as per PSO 2700”

The Governor should consider what ongoing guidance and support is available for staff acting in the family liaison officer role.

The Prison Service has accepted this recommendation, commenting:

“Due to infrequency of DIC [death in custody] incidents, those performing Family Liaison Roles should attend refresher training, and be desk-topped during contingency planning exercises.”