Investigation into the circumstances surrounding the death of a man at HMP Wealstun in July 2009

Report by the Prisons and Probation Ombudsman for England and Wales

October 2010

This is the report of an investigation into the circumstances surrounding the death of a man in July 2009. The man, who was only 22 years old, died whilst using the gymnasium at HMP Wealstun. His health had appeared to be good and his death was sudden. Despite a swift response to the emergency, he died from a spontaneous burst blood vessel within the skull.

The man arrived at Wealstun in February 2009 after spending the previous three weeks in HMP Leeds following his conviction for wounding with intent. This was his first time in prison, except for a brief spell on remand, related to these charges, in September 2008. The man had been working steadily towards a move to an open prison and category D status as part of his sentence plan.

I extend my personal condolences to the man's family and friends for their loss. The loss of a loved one at any time is difficult, but especially so when they are so young, die unexpectedly and are in custody. I am conscious that this investigation report has been delayed and that this will only have added to the family's grief. The clinical review took time to complete due to a regrettable delay in receiving the post mortem report.

This investigation was carried out by one of my colleagues. A clinical review, for which I am most grateful, was undertaken by a clinical reviewer on behalf of Leeds Primary Care Trust. I would also like to thank the Governor of HMP Wealstun and her staff for their help and co-operation during this investigation.

I make five recommendations in this report, together with a suggestion that Leeds PCT consider the implications of the further recommendations made by the clinical reviewer in his clinical review.

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.

Jane Webb
Acting Prisons and Probation Ombudsman **October 2010**

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SUMMARY

The man who is the subject of this report was sentenced to nine years imprisonment on 12 January 2009 at Crown Court for wounding with intent to cause grievous bodily harm. He was sent initially to HMP Leeds and then to HMP Wealstun on 3 February. No health problems were recorded when he arrived in prison, though he had used drugs in the past and was a heavy smoker. He had never been to prison before.

When the man first arrived at Leeds, he found the shock of prison and the length of his sentence hard to accept. Staff were concerned about his welfare and decided to monitor him on special observation measures, known as Assessment, Care in Custody and Teamwork (ACCT). He seemed to adjust to his situation quite quickly and the ACCT document was closed on 21 January.

After a difficult start to his time in Wealstun, the man settled down to work hard at offender management courses with the aim of gaining category D status and a move to an open prison as soon as he was eligible. He completed a Prisoners Addressing Substance Related Offending course (PASRO) and received glowing reports from tutors for his participation and eagerness to engage in the course.

Although the man complained of frequent headaches, and his blood pressure was twice recorded as high, the significance of these events for someone so young was not appreciated. No further investigation of these health issues was thought necessary by medical staff at Wealstun.

On 12 July, the man went to the gymnasium, as he had on a number of earlier occasions. He started his warm up exercises and suddenly collapsed. Prisoners around him raised the alarm and staff came to the man’s assistance. An emergency call was made to healthcare staff via the radio, but unfortunately the urgency of the situation was not relayed to them. When nursing staff arrived, they soon realised that the man needed urgent intervention as he had stopped breathing. An ambulance was called for and cardio pulmonary resuscitation began.

When the paramedic team arrived, they transferred the man to outside hospital. The prison tried to contact the man’s family, but a prisoner with an illicit mobile telephone had already managed to inform them that he was unwell and had been taken to hospital. The man’s family reached the hospital very quickly but, by the time they arrived, he was unable to breathe without the use of medical equipment. The man’s family sat with him whilst he passed away without regaining consciousness. The cause of his death was recorded as an intracranial haemorrhage, that is bleeding within the skull. The clinical review contains more detail about this condition.

THE INVESTIGATION PROCESS

1. This investigation was undertaken by one of the investigators from this office. He first visited Wealstun on 20 July 2009 and was given access to the man's prison records. The investigator visited the gymnasium and was shown around other places within the prison such as the healthcare unit and the unit where the man lived during his time at the prison.

2. During this initial visit, the investigator met members of the Independent Monitoring Board (IMB) and the Prison Officers Association (POA). He invited them to provide any information regarding the prison or the circumstances surrounding the man's death that they thought pertinent to my investigation. (Each prison has an Independent Monitoring Board. IMB members are unpaid and monitor day-to-day life in the prison to ensure that proper standards of care and decency are maintained. The IMB produces an annual report of its work.)

3. Leeds Primary Care Trust (PCT) was asked to undertake a clinical review of the care that the man received whilst he was in custody, particularly during his time at Wealstun. They appointed a clinical reviewer to undertake the review on their behalf. The clinical reviewer was asked by the investigator to consider particularly the cause of the man's collapse and any actions that could or should have been taken in respect of cerebral haemorrhage before his death.

4. One of my family liaison officers contacted the man's mother, as his listed next of kin, and invited her to ask any questions or raise any issues for consideration as part of my investigation. The family were very appreciative of the efforts the prison had made to help them through this difficult time. They said that they were reassured by their visit to the prison and the memorial service held in the man's honour. The family asked for additional clarity about the emergency response and whether everything was done as quickly as it could have been – a matter that is covered within this report. They were also aware that the man had complained of toothache and headache and they wished to know if these problems were related to his death. I hope my findings help the man's family better understand what happened following his collapse and address any concerns they may have about the care he received.

5. My investigator contacted Her Majesty's Coroner to inform him of the nature and scope of my investigation and to request a copy of the post mortem report. Upon completion of this investigation, a copy of my report will be sent to the Coroner to assist his enquiries into the man's death.

HMP WEALSTUN

6. HMP Wealstun is a category C training prison for adult males. It opened on 1 April 1995, following the amalgamation of HMP Thorp Arch and HMP Rudgate to form a Category C (closed) side and Category D (open) side within one establishment. In 2008 the open prison closed and is currently undergoing a conversion to provide additional category C places. The full prison is scheduled to commence operation later in 2010.

7. Wealstun was a large and complex establishment when it was two prisons within one operation. When Her Majesty's Chief Inspector of Prisons made her announced full inspection visit in 2008, she said:

> 'On our previous visit, we were critical of the complexity of the site, which included an open prison. On our return, the open side was empty and in the process of being converted into additional closed training places. Wealstun was clearly benefiting from the single focus that these changes had brought about. Improvements were visible across the board, with particular progress having been made in resettlement provision.
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> 'There had been significant improvements at Wealstun since our previous visit. The prison had clearly benefited from the increased clarity of role that had come with the closure of the open prison, leaving it to focus fully on its category C training function.
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> 'Bullying and violence reduction arrangements had also developed, although more individual work was needed with bullies and their victims. Drugs remained a significant problem, but security arrangements had been tightened proportionately to address the issue.'

8. When a prisoner first arrives at a prison, they undergo an induction process. This is to ensure they are given information about the prison and to ascertain if there are things that need doing for them (perhaps as part of their healthcare needs, perhaps as part of their offence management needs). Part of this process will usually include an induction for the use of the gymnasium, should they wish to use that facility. After prisoners have applied to join the gym, they are normally collected by staff for an induction and assessment session. Every prisoner who applies is entitled to be assessed. The induction process involves a one to one interview with a PEO, during which the prisoner is introduced to the equipment and shown how to lift weights safely. The rules are explained and a Physical Activity Readiness Questionnaire (PAR-Q) is completed, as per Prison Service Order (PSO) 4250. Prisoners are asked about their medical history and if they are taking any medication. The PSO states:

> 'All prisoners may participate in PE activities. Prisoners will not be restricted unless otherwise authorised by the Governor and/or a Healthcare professional. All PE departments must deliver a

comprehensive induction programme, which must include as a minimum requirement:

‘Explanation of PE rules and regulations…

‘Instruction on basic weight training, safe use of PE equipment and machinery…

‘A Physical Activity Readiness Questionnaire (PAR-Q) must be completed for all prisoners on PE induction prior to participating in PE activity and signed by both the prisoner and a member of PE staff…

Elements of first aid, safe handling and lifting.’

9. The induction process into the gymnasium should include each piece of equipment being demonstrated as to how to use it safely and properly, how to warm up properly and the importance of doing this as well as doing cooling down exercises. The induction should also include what to do if an injury occurs or if someone feels unwell after using the gym. The man was a regular user of the gymnasium and was deemed competent to use the facilities with minimal supervision.

10. This was the first death that the Ombudsman has investigated at Wealstun since the office began investigating deaths in prison custody in 2004. There have subsequently been two other deaths, one from natural causes. There are no obvious similarities between this man’s death and the others.

KEY FINDINGS

11. On 10 September 2008, the man was remanded into custody at HMP Leeds on charges of wounding with intent to cause grievous bodily harm. He was released on bail on 23 September. After his trial and conviction in January 2009, he was sentenced to nine years imprisonment at Crown Court on 12 January. He returned to Leeds from court.

12. When the man arrived at Leeds he underwent an induction process, including initial and secondary health screening. This identified that he had no medical problems and was fit to be located anywhere in the prison and undertake any work that was offered him. His clinical record shows that he smoked about 30 cigarettes a day and that his blood pressure was 154/96 (which is slightly high for a young man of 22). He denied any drugs use at this assessment. He also scored three points on a suicide risk factor scale (because he was under 25 years old and his offences were of a serious nature). The trigger point of concern on this scale is ten or more points. He was therefore not thought to be at risk of harming himself.

13. However, during the night of 13 January, the man asked to see a nurse because he was having problems sleeping. He was seen by a nurse who was unable to give him any medication to help because none had been prescribed by the doctor.

14. Later that day the man saw a further nurse because he felt upset, partly because of the length of his sentence and partly because he was having problems sleeping. The nurse thought that the man presented a risk of suicide or self harm and she decided to put him on special observation measures, known as Assessment, Care in Custody and Teamwork (ACCT). (The ACCT document is used to monitor and support prisoners thought to be at risk of suicide or self harm through a period of crisis.) Leeds also has a Safer Custody programme which enhances the ACCT process, and the man was put forward for this extra help.

15. The man seems to have settled down after this with the support of wing staff. His ACCT was closed on 21 January and the post closure review report says:

    > '[The man] has accepted his circumstances. The uncertainty he felt at the start has largely gone and he is looking forward to getting to a Category C training [prison].'

    (The post closure review is a mandatory part of the support process for prisoners who have been the subject of ACCT.)

16. On 31 January, the man appeared at a Magistrates' Court to answer four charges of possession of drugs. He was sentenced to 28 days imprisonment to run concurrently with his existing sentence.

17. The man transferred to HMP Wealstun on 3 February. This was a move that he had wanted as it made it easier for his family to visit, and the regime was more relaxed than at Leeds, due to its lower security category.

18. As part of his reception screening on arrival at Wealstun, the man was seen by a nurse. He wrote in the man's medical notes that the man had been suffering with 'blurred vision and headaches for six months' and advised that he see a prison doctor. There is no evidence to suggest that he did see the doctor at this time.

19. On 23 February, the man told his personal officer that he was being bullied in the workshops. He said that prisoners, whom the man would not identify, had been throwing things at him. He had 'squared' up to one of those prisoners (as reported by the personal officer in the man's wing history sheet). His personal officer offered the option of changing his place of work. His personal officer also checked that the man was alright on 2 March (the indication from the record is that the personal officer was referring to the man's problems at work). The man assured his personal officer that he was.

20. Throughout February, the man complained of headaches for which he was given paracetamol. On 6 March, he was seen by a doctor regarding the headaches. He told her that he had been having them for the past two months, several times a day, and had also been waking up early and having nightmares. He told the doctor that the paracetamol had alleviated his pain.

21. The doctor checked the man's blood pressure which was again slightly raised at 160/100 and also arranged for blood tests to be undertaken. The results of the blood tests showed nothing significantly wrong with the man except a high level of cholesterol. She prescribed Naproxen for his headaches and Promethazine to help him sleep. No specific arrangement was made to review him in the future.

22. The man was accused of bullying by another prisoner on 23 March. Staff interviewed him and he told them that he was being targeted by some individuals. The man told a senior officer (SO) that the problems stemmed from the fact that he would not back down to prisoners trying to intimidate him. The senior officer advised that the man try not to get involved. He was moved to a different landing on 24 March with the express aim of trying to alleviate the tension between him and some other prisoners.

23. On 25 March at approximately 11.30am, the man was involved in an altercation with one of the prisoners that he had been having problems with. The man told staff later, when he was being interviewed about the incident, that he and the other prisoner had originally been friends, the man even paid off one of his friend's debts. However, it seems that this friendship had recently broken down which resulted in the argument. The man was again advised to 'behave maturely and walk away'. The man was further advised that staff would be keeping a close watch on him over the following week.

24. A few days later on 30 March, things apparently escalated. The man was seen throwing an apple at the prisoner he had been having problems with and a heated argument followed. Both individuals separated when staff approached and the man was put on report for breach of prison rules. He was adjudicated on 1 April and pleaded guilty (an adjudication is a prison disciplinary hearing). His punishment was to spend the next three days in the segregation unit and have half his wages stopped for seven days (but this was suspended for one month). He was also not allowed to buy anything with his personal cash for seven days or allowed on association for three days, but this again was suspended for one month. In effect, providing he did not get into any more trouble for the following month, his sole punishment would be the three days in the segregation unit.

25. When the man was released from the segregation unit on 4 April, he did not go back to D wing but instead moved to B wing.

26. The man had started a PASRO course some time in March, though his prison records do not indicate clearly when the course began. Due to his time in the segregation unit, he was ‘deselected’ from the course on 2 April. On 6 April he asked for an explanation for his place being withdrawn. The response from the PASRO treatment manager was that he was not allowed to miss more than one session in any one module or more than two consecutive sessions throughout the programme. He was also not allowed to miss more than three sessions during the entire programme. The man had missed sessions 15 and 16 of the programme and therefore he was automatically deselected. However, his end of course report was nevertheless encouraging and he was recommended to go on the next available course, scheduled for May.

27. The man was found using the telephone on 8 April at a prohibited time. He told an officer that he was telephoning his solicitor which proved to be a lie. The officer advised him not to tell lies to staff. The officer had occasion to reprimand the man on 20 April, when he was overheard being rude about her. His wing history sheet indicates that he was rude or confrontational with staff on 29 April and again on 11 May.

28. On 23 May, the man moved wings again, this time to C wing. One of the prisoners he had problems with was also on C wing. It seems from records that staff were aware there might be problems, but that both the man and the other man reassured staff that there would not be any problems. There is evidence to suggest that they played pool together on a number of occasions.

29. The following week, on 29 May, the man was involved in a near fight with another prisoner. Staff intervened immediately and no actual physical contact occurred between the prisoners. Both prisoners were placed on report and punished by the Governor by seven days loss of association and seven days loss of television. They also lost the facility to spend their private cash for seven days.

30. In May or June (again it is unclear exactly when) the man started the PASRO course. He completed the course on 15 June, this time with glowing praise from the tutors. It appears from his end of course reports that the man showed a tremendous desire to succeed this time and had markedly improved his behaviour, attitude and outlook on his offending behaviour.

31. The man had been complaining of dental pain for a while. He asked to see the dentist on 19 and 23 February, 23 March, 27 April, 5 June and 16 June. On 29 June, he was seen by the visiting dentist who removed a tooth which had quite a lot of decay evident. The dentist gave the man some advice about what to do if the socket bled and also suggested that he needed some further work, which might include another extraction.

32. On 2 July, the man made an application to see a nurse because he said 'I had a tooth out last week, they took the wrong tooth out and I am in agony'. He was initially referred back to the dentist, but he had not been seen by 8 July when he repeated his request. The dentist saw him the following day and assured him that he had taken the right tooth out.

Events on the day of the man's death

33. At approximately 9.15am the man and other prisoners entered the gymnasium area for a free weights training session. The man started by doing some warm up exercises with a 'curling bar' (a bar with weights either end) to exercise his arms. He was partnering a fellow prisoner and the man had completed two sets of 20 repetitions of a curling exercise. The man's gym partner was part way through his second set of exercises when he saw the man walk in front of him in an unsteady manner and collapse to the floor. The man's gym partner immediately rushed over to the man, together with two other prisoners. They shouted for staff assistance.

34. A Physical Education Officer, (PEO), who was ten feet away in the gym office, rushed out and crouched down beside the man. He found the man lying face down on the floor with blood coming from his nose (it appears the man struck the wall as he fell). The PEO saw the man have what he described as a fit (or seizure) and he was only half responsive to his verbal commands. The man was breathing, but in a noisy way.

35. They were joined by a second PEO who, when he saw the man collapsed on the floor surrounded by people, raised the alarm using the radio at 9.20am. When the second PEO first called for urgent assistance, the communications officer did not hear the full transmission and asked the PEO to repeat his urgent message. The second PEO repeated his request for urgent attendance of healthcare staff to the gymnasium, together with a request for an ambulance.

36. An Operational Support Grade (OSG), who was in the control room, radioed for healthcare staff to go to the gymnasium. He also tried to telephone the ambulance service using the 999 facility. The OSG was unable to get through

37. Meanwhile, one of the PEOs and a prisoner had put the man into the recovery position, trying to make him as comfortable as possible. The man was breathing but was semi-conscious and not responding properly to verbal commands.

38. It seems evident from staff incident reports that healthcare staff did not at first appreciate the urgency of the situation in the gymnasium. At 9.25am the nurse who had seen the man as part of his reception screening on arrival at Wealstun received another call for healthcare staff to report to the gymnasium as swiftly as possible. He had already started out for the gym but returned to the healthcare unit to collect an emergency bag. The nurse assumed that he would be attending to a sporting injury and he therefore selected the red emergency bag with equipment to treat cuts and injuries.

39. The nurse arrived at the gymnasium at approximately 9.30am. He saw that the man was in the recovery position and that one of the PEOs and a prisoner were present. The man was breathing and had a pulse, but did not respond when the nurse talked to him. Within a minute of his arrival, the nurse became aware that the man had stopped breathing.

40. The prisoner and the PEO moved the man on to his back and the nurse checked for a pulse. He could not find one, so he started chest compressions and the PEO commenced rescue breaths (cardio pulmonary resuscitation, that is CPR).

41. The nurse attempted to call one of his colleagues by radio. He was unable to get through using this method. He asked one of the officers to call nursing staff by telephone, and ask them to come to the gym and bring the defibrillator with them.

42. A nurse responded to this request at 9.35am (although his recollection is that he responded to a radio call). When he arrived, the nurse asked the nurse who saw the man as part of his reception screening on arrival at Wealstun and the PEO to stop CPR whilst he attached the defibrillator to the man. The automatic external defibrillator (AED) advised staff to stand clear whilst it administered an electric shock to the man. (An AED is a sophisticated, reliable, safe, computerised device that delivers an electrical shock to a person in cardiac arrest. It uses voice and visual prompts to guide the person using the machine, and is suitable for use by lay people and healthcare professionals. AEDs analyse the person’s heart rhythm, determines the need for a shock, and then delivers a shock. A semiautomatic AED advises the need for a shock, but it has to be delivered by the operator when prompted.)

43. After it had done this, CPR resumed in accordance with the protocol for dealing with someone in cardiac arrest. The nurse who had attached the defibrillator to the man asked the communications officer to contact a further nurse to bring the blue emergency bag to the gymnasium. They were not

44. The nurse arrived at the gymnasium with the blue emergency bag at approximately 9.45am. The nurse who had attached the defibrillator to the man took out a guedel airway and inserted it into the man's airway to assist the delivery of oxygen. During this time, the AED had been used continuously to monitor whether the man needed, or should be given, further shocks to restart his heart. No further shocks were given, but CPR continued.

45. At approximately 9.50am an ambulance arrived at the prison. When the paramedics entered the gymnasium, they used their own equipment to assess the man's condition. Their AED advised initially that the man was in a state of pulseless electrical activity (PEA), which means that a shock should not be delivered. The paramedics administered adrenaline and atropine via a cannula they inserted into the man's neck. They rechecked the man's condition using their AED and this time it advised that a shock should be given.

46. The paramedics stabilised the man over the following 30 minutes and left the prison with him in the ambulance. His pulse was 102 beats per minute and his blood pressure reading was 92/59. (These readings mean that the man's heart was beating a little fast and his blood pressure was lower than normal.) They took him to outside hospital with two prison officers escorting him.

47. After the man left the prison, the duty governor tried to contact his family. Her initial attempt appears to have failed, but she managed to speak with the man's mother at approximately 10.47am. She told her that her son had been taken to outside hospital and that she should go there as soon as possible. Unbeknown to the duty governor, the man's family had already been told that something had happened to him by a prisoner who had a mobile telephone and knew his family.

48. When the man arrived at hospital, doctors put him on a life support machine and arranged for a CT scan of his head. (A CT scan is a method of x-raying the body using computed tomography and displaying the images so that doctors can make an internal assessment.) The doctors at the hospital asked colleagues at another hospital for their specialist advice. The advice from this second hospital was that the man's condition was fatal and that he was unlikely to recover from the bleed that had occurred within his skull.

49. The man's family arrived at hospital in time to be with him before he passed away. His life support machine was turned off and he was pronounced dead at 5.34pm.

Events after the man's death

50. Following a serious incident of this nature, the Prison Service has a procedure for ensuring the welfare of everyone who may have been affected. It is expected that family members are kept informed. Staff and prisoners should be offered help and support. Any lessons to be learned and changes to policies and procedures that are necessary, must be swiftly implemented.

51. I am broadly satisfied with the way in which Wealstun discharged these responsibilities. The Family Liaison Officer appointed by the Governor kept the man's family informed of what was happening regarding his property and memorial service arrangements. The police were reluctant to allow free access to his cell until they were certain what had caused the man's death. These investigations took some time and resulted in the family never actually seeing the cell he had occupied. The family advised me that this has caused them some distress. After I had issued the draft report, my investigator contacted the prison to ask whether the Governor would consider re-issuing the invitation to the man's family to see where he had lived. The prison stated they would be happy to facilitate a visit should the family still wish it.

52. The prison organised a 'hot debrief' following the man's death. This meeting was attended by all the staff involved in the emergency and highlighted the communication difficulties. Staff interviewed by my investigator agreed that they had found the debrief useful. Everyone also said they had been offered staff care and welfare services.

53. My investigator spoke with a number of prisoners on his visits and asked if they had been well cared for following the man's death. There were mixed responses, but most prisoners told my investigator that they had been well cared for. However some prisoners said that more support could have been offered over a prolonged period.

ISSUES

Clinical care

54. Of significance to the man's care is whether efforts should have been made to identify that he was at risk of an intracranial haemorrhage (also known as cerebral or sub-arachnoid haemorrhage) in the first instance. The clinical reviewer for Leeds PCT reports that the man had two blood pressure checks, both of which showed he had raised blood pressure. He also had grossly elevated cholesterol levels, was a heavy smoker and had complained of frequent and persisting headaches. All of these 'markers are risk factors for cerebrovascular pathology [disease or condition of the blood vessels within the skull]'. High levels of cholesterol cause fatty deposits to build up within blood vessels. This in turn can lead to a narrowing of those vessels making it harder for blood to flow around the system. This usually presents a problem within the vessels of the heart, but can also present problems in any part of the body, including the brain.

55. The clinical reviewer for Leeds PCT goes on to say that the single biggest risk indicator for cerebrovascular problems (problems with the blood vessels within the skull) is persistently elevated blood pressure coupled with headaches. The clinical reviewer finds that:

> 'it is not possible to determine whether or not these headaches were related to the sub-arachnoid haemorrhage and raised blood pressure but it is certainly possible that they gave an indication that the blood pressure was raised.'

He recommends that more should have been done to determine the cause of the headaches and raised blood pressure. He says:

> 'The fundamental criticism of [the man's] care is that his persistently raised blood pressure in association with headaches was not managed appropriately. He should have had more intensive blood pressure monitoring with planned reviews and supported lifestyle interventions until his blood pressure returned to normal or a diagnosis of hypertension was made.
>
> 'The context of his persistent problem with headaches and his subsequent death from a sub-arachnoid bleed coupled with raised blood pressure certainly suggests that there was an opportunity to intervene in a more substantive way to help him which was missed.'

56. The clinical reviewer considers the assumption that the man's raised blood pressure was due to stress was probably incorrect.

The healthcare manager at Wealstun should arrange a programme of training and education for all healthcare staff about conditions such as raised blood pressure and other long-term condition management and monitoring.

The PCT should review the systems for the diagnosis and management of long-term conditions and ensure they meet current expected delivery models for GP practices in the community.

57. However, even if all of these additional measures had been put into place, the clinical reviewer considers that the cerebral bleed from the vessels at the base of the man's brain would probably only have been delayed and might have occurred at some time in the future. This is because of the congenital nature of his condition.

Illicit drug use

58. There is some suggestion in the post mortem report that the man's death may have been related to illicit drug use. It is certainly a matter of record that he was convicted of possession of drugs at a Magistrates' Court on 31 January 2009. However, he also denied any substance misuse at his initial reception into Leeds on 12 January. The clinical reviewer considers there is no specific evidence that illegal drug use contributed to the man's death. The Mandatory Drug Tests performed whilst he was in prison showed no evidence of substance misuse. After issuing the draft report my investigator established that the man had signed a voluntary agreement to remain drug free as part of his PASRO course. The man undertook voluntary drug tests on various dates between March and 29 June. The results of these voluntary tests were negative each time, with the exception of one positive result for cannabis on 18 March.

Response to the emergency

59. The evidence suggests that there was a great deal of confusion in the prison's response to the medical emergency in the gymnasium. When the man first collapsed at approximately 9.20am PE staff responded very quickly. A PEO immediately summoned help from healthcare colleagues using the radio system. It seems that his initial request could not be properly heard or understood, but he succeeded in getting his urgent message across. The OSG in the communications room apparently relayed his urgent request to healthcare staff. However, it was not until 9.30am that the nurse who saw the man as part of his reception screening on arrival at Wealstun, arrived at the gymnasium, and even then he was carrying equipment that was inappropriate for the man's needs.

60. Meanwhile the OSG had been asked to contact the ambulance service using the dedicated 999 emergency telephone. He found it impossible to be connected and had to resort to telephoning the main prison gate to ask them to telephone the emergency services on his behalf.

61. In the gymnasium, the nurse who saw the man as part of his reception screening on arrival at Wealstun was aware that he did not have the necessary equipment to hand when the man went into cardiac and respiratory arrest. The nurse tried to use his radio to call for one of his nursing

62. The nurse used the defibrillator to administer a cardiac shock to the man, in accordance with the machine's instructions. He recognised that he needed further equipment to treat the man. He used his radio to ask the communications room staff to ask a nurse to bring the blue emergency bag to the gymnasium. His initial request did not achieve the desired result and it was only at this point that the radio system was put into 'talk through' mode – something that should have happened immediately the Urgent Message was first sent by the PEO.

63. From this point on, it seems that communication improved. There are a number of observations I would make regarding the communications difficulties. The first centres on the use of the radio as a means of communicating an emergency to all staff. The most usual method for operating a radio system is for the radio to be used as a two way communication device between a member of staff with a radio and the communications centre. Staff in the communications room can then control who they communicate with. In the event of an emergency, the communications officer can choose to change the mode of communication and set the radio system to 'talk through' which means that all those with a radio can hear what everyone who transmits says. The communications officer has little or no control over what is transmitted. It is a matter for the communications officer as to which system is deemed most appropriate according to the situation at the time. In this case, I think it would have been preferable that the radio system be changed to 'talk through' sooner.

The Governor should remind staff in the communications centre of the importance of clear and concise information exchange in emergency situations. She should advise staff in the communications centre of the correct use of urgent message procedures such as putting the radio system to talk through mode.

64. There was also a communications problem contacting the emergency services. The 999 emergency telephone system failed at a time when it was most needed. Fortunately, the OSG used his initiative and contacted his colleagues in the prison gate area to ask them to use their telephone to make the emergency call. Little time was lost contacting the emergency services. As it was, it took the paramedics some 25 minutes to arrive at the man's side in order to assist him. During that time, nursing staff, assisted by one of the PEOs, started CPR and defibrillation attempts.

The Governor should ensure that regular checks are made of the integrity of the emergency telephone system, and that a register is maintained of these checks.

65. The clinical reviewer for Leeds PCT comments on the emergency response after the man's collapse. He says that, despite the fact there was evident delay in the resuscitation process, he does not believe this delay contributed to the man's death. He makes the point that the gymnasium staff and prisoners who assisted the man in the first instance should be commended for their actions. He says that the paramedics who attended were 'skilful' in their canulation and administration of medication to the man. I note also the significant effort of healthcare staff to revive the man. According to the clinical reviewer, once the man's intracranial haemorrhage had occurred, there was little chance of him surviving 'such a massive brain insult'.

66. There was some confusion surrounding the emergency equipment required to assist staff in resuscitation efforts for the man. The first member of healthcare staff attending the gymnasium took a red bag which is used for cuts and minor injuries. When he arrived and the man suddenly stopped breathing, he realised that he needed a defibrillator. He then had to ask officers to arrange for another nurse to bring the equipment to the gymnasium. When the second nurse arrived he realised he needed further equipment to aid the man, which was in the 'blue' bag. They had to again make arrangements for this to be brought to the gymnasium.

67. It is difficult to establish the most effective location for emergency equipment within a prison. However, I am sure it is possible for Wealstun to improve on the arrangements in position on 12 July 2009.

The Governor and healthcare manager should ensure there is sufficient emergency equipment, including defibrillation machines, available within the prison and that sufficient staff are trained in the use of such equipment. They should also consider ways of ensuring all staff are aware of where the nearest emergency equipment is stored.

Informing the man's family

68. As soon as it became clear to managers at Wealstun that the man's health was in jeopardy, they made arrangements to notify his family. Unfortunately, a prisoner who knew the man and his family had already used an illegal mobile telephone to inform them. This caused a degree of embarrassment to the prison authorities. I commend the prison for taking early steps to inform the man's family that he was gravely ill. My experience is that other prisons have not always informed families rapidly. It was unfortunate that the news had already been communicated to the family by illicit means.

Wing history records

69. One matter that came to my attention during the course of this investigation was that staff at Wealstun stopped using hand written entries in the wing history sheets in early June, moving then to a new electronic recording system called P-NOMIS. Unfortunately, there do not appear to be any further wing history entries in respect of the man after 7 June. My investigator brought this to the attention of staff on his initial visit to the prison on 20 July.

CONCLUSION

70. The man had some risk indicators associated with intracranial haemorrhage. In particular he had high cholesterol levels, smoked and had high blood pressure. However, he did not present as someone with health problems. He appeared to be a fit 22 year old who enjoyed sport and using the gymnasium.

71. It may be that the man had a weakness in the blood vessels within his brain which had been present since birth. The clinical reviewer says in his clinical review that:

> 'Such haemorrhages are well recognised in young adults and are usually caused by a congenital aneurysm in the cerebral vasculature at the Circle of Willis at the base of the brain.'

72. There is no evidence to suggest that the man suffered any trauma to his head before he fell in the gymnasium. Any injuries are thought to have been caused after he collapsed unconscious as a result of a burst aneurysm. There is no evidence that the man's haemorrhage was caused by illegal substance misuse, despite the hypothesis in the post mortem report. The clinical reviewer believes that the man suffered an intracranial haemorrhage because of a weakness in one or more of the blood vessels within his brain. This may have been something he was born with, but remained undetected until he collapsed in the gymnasium. According to the clinical reviewer, there was little chance that he would survive such a sudden and massive bleed. I am satisfied that, despite the initial confusion, prison and healthcare staff could not have done anything to save the man's life. He was a very young man and his passing is a loss to his family and especially his young children.

RECOMMENDATIONS

The Prison Service responded to these recommendations and has provided an action plan in respect of each one. Their comments are recorded below each recommendation.

1. The healthcare manager at Wealstun should arrange a programme of training and education for all healthcare staff about conditions such as raised blood pressure and other long-term condition management and monitoring.

Partially accepted: All clinical healthcare staff are trained during initial training and have annual updates and any training needs are identified through the PPD report. Update training in long term condition management will be given via the City Wide Team. *Target date October 2010.*

2. The PCT should review the systems for the diagnosis and management of long-term conditions and ensure they meet current expected delivery models for GP practices in the community.

Accepted: Systems are already in place for the management of long term conditions as per the GP's practice as GP Service is provided by a GP Practice in the community and is supported by a prison health city wide team.

3. The Governor should remind staff in the communications centre of the importance of clear and concise information exchange in emergency situations. She should advise staff in the communications centre of the correct use of urgent message procedures such as putting the radio system to talk through mode.

Accepted: Directly following the incident involving the man, the OSG was spoken to regarding the ways in which communication may be better improved by placing the radio net onto "talk through" during urgent message scenarios.
It was also recommended that during briefings with the OSG group by managers this is also reinforced, particularly after this event and whilst it was fresh in staff's memories. More recently the "urgent message" procedure has been further reinforced due to unconnected issues with the reliability of the General and Fire Alarm systems. Every member of staff within the prison would have been informed of the expected action which will be taken in response to an "urgent message" communication. The OSG group would have received additional support in ensuring this is understood and carried out where necessary. Further support to be considered is refresher Control Room Operatives training for all members of the OSG group. To be arranged via regional training services. *Target date 30 September 2010*

4. The Governor should ensure that regular checks are made of the integrity of the emergency telephone system, and that a register is maintained of these checks.

Accepted: The initial report that the OSG was unable to contact emergency services via 999 within the Control Room was taken up immediately with the IT Manager. An email communication was sent to every member of staff (24/7/09) advising that although 999 calls can be made from the Control Room the "ringing tone" expected

when the call is first made does not sound. Tests were carried out and confirmed that the call is connected in the normal manner other than this anomaly, and that this is something which cannot be changed. 999 access via the Gate was also confirmed as working in the normal manner. To date regular checks of this line are not made but this will be taken up as a matter of urgency after consultation with the Police Control Room, who receive emergency calls, as to when would be the best time to make such tests so as to have as minimal impact on their own call centre function and emergency processes which should not be disrupted. The IT Manager at HMP Wealstun is also to be involved in this system.
Target date 31 July 2010.

5. The Governor and healthcare manager should ensure there is sufficient emergency equipment, including defibrillation machines, available within the prison and that sufficient staff are trained in the use of such equipment. They should also consider ways of ensuring all staff are aware of where the nearest emergency equipment is stored.

Accepted: This has been reviewed by the Healthcare Manager and the PCT Area Manager and is to be implemented at strategic points of the prison by August 2010. Further emergency equipment has been identified by the Service Development Lead and has been ordered. *Target date August 2010.*