

**Circumstances surrounding the death of a man
in August 2005 at hospital,
while a prisoner at HMP Parkhurst**

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

October 2006

This is the report of an investigation into the circumstances surrounding the death of a man in August 2005. At the time of his death, the man was a prisoner at HMP Parkhurst. He had been admitted to hospital after a collapse, and was found to have had a heart attack. He did not regain consciousness.

He was a relatively young man, aged 44, who had previously had little need of healthcare services. I would like to extend my condolences to his family and friends for their sad and unexpected loss.

The investigation was carried out on my behalf by a colleague. Unfortunately, the investigator experienced considerable hold-ups before being able to carry out her interviews, and I must apologise for the consequent delay in producing this report.

An independent review into the man's medical care and treatment was undertaken by Isle of Wight Primary Care Trust. I am most grateful for their assistance. I am also grateful to the Governor and staff of Parkhurst for their co-operation with this investigation.

Although one prisoner has alleged that there were delays, I am satisfied that prison staff responded appropriately to this emergency. Indeed, this is a report that generally reflects well upon HMP Parkhurst. That said, I include five recommendations. I also highlight the initiative of two members of staff who provide first aid training for their colleagues.

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Summary

The man who is the subject of this report, was sentenced to 14 years imprisonment in September 2003, for an offence of drug importation. This was his first and only period of imprisonment. He appealed against both his conviction and his sentence and successfully had his sentence reduced to 12 years.

After a period of time at HMP Wandsworth, the man was transferred to HMP Parkhurst. He soon made some close friends there and, after induction, settled onto C wing.

It was the man's custom on a Saturday, along with his two friends, to cook a West Indian meal. They would spend the morning preparing, and later in the afternoon would meet in one of their cells to eat whilst watching a film.

On a Saturday in early August, the man and his friend went to the kitchen and cooked their meal. They then returned to his younger friend's cell to serve it. Suddenly, the man collapsed and slumped against the back wall of the cell.

His older friend started to fan the man with a towel while his younger friend called from help. He then pressed the emergency cell bell. Within two minutes, seven members of staff were in attendance and had started Cardio Pulmonary Resuscitation (CPR). Healthcare staff then arrived and took over, while an ambulance arrived soon afterwards. The man was taken to a local hospital but, sadly, did not regain consciousness.

The clinical review, carried out as part of this investigation, does not identify any specific issues relating to the clinical care the man received. It says that he received nursing and medical care comparable to that which would have been available in the community. However, this report does raise some important issues relating to the management of the news of the man's illness and death.

Investigation process

1. The investigation was opened in September 2005, by my investigator. She issued notices announcing the investigation to staff and prisoners at Parkhurst and inviting anyone who wished to see her to make themselves known. As a result, a friend of the man wrote to the investigator. He was subsequently interviewed together with another of the man's friends.
2. My Investigator visited HMP Parkhurst in November 2005, when she was provided with the man's prison record and copies of the notices, reports and other documents associated with his death.
3. Four additional visits were necessary in order to complete the interviews. This report is based on those interviews, a thorough review of all relevant records, and consideration of the findings of the clinical review.
4. As part of her enquiries, my investigator also spoke to the Isle of Wight Police who had carried out their own investigation into the man's death. She made contact with the Coroner's office to inform him of our investigation. Isle of Wight Primary Care Trust conducted a clinical review of the man's care while in custody.
5. The investigator also gathered details of the man's next of kin and one of my Family Liaison Officers contacted the man's family. Their only concern was that the man had not been attended to quickly when he was taken ill. They also asked to be informed when the draft report was completed.

HMP Parkhurst

6. HMP Parkhurst is a category B training prison for sentenced adult male prisoners, situated outside Newport on the Isle of Wight. It also holds unconvicted adult male prisoners awaiting trial at court on the Isle of Wight. At the time of the man's death, it held just over 500 prisoners.
7. Vulnerable prisoners are held on A and D wings. B and G wings hold prisoners on basic and standard regimes, while C wing is an enhanced regime. F wing holds remand prisoners and non-vulnerable prisoners on induction. There is also a segregation unit, a protected witness programme and an in-patients healthcare unit.
8. Healthcare is commissioned by the Isle of Wight Primary Care Trust. The healthcare centre provides 24 hours cover and has 12 in patient beds. The most recent inspection report by Her Majesty's Chief Inspector of Prisons in August 2005, noted that the healthcare service at Parkhurst was "fragmented and understaffed". However, healthcare provision had improved from the previous inspection in 2002.
9. I have investigated two other deaths from natural causes at Parkhurst. I have found no similarities between those deaths and this case.

Events leading up to the man's collapse

10. The man was remanded into custody in December 2002 at HMP Wandsworth. His 'First Reception Health Screen' form reported that he had no health concerns, either physical or mental, and did not use drugs, drink or smoke. The clinical reviewer commented that no significant past medical history or other health risks were recorded. In September 2003, the man was sentenced to 14 years in prison. This was later reduced to 12 years, on appeal.
11. The clinical reviewer notes that there are a number of entries in 2003 and 2004, in the man's medical record, reporting that he was fit and well.
12. In August 2004, while still at Wandsworth, the man completed an application form saying he needed to see a doctor urgently, stating that he had already completed a medical application. The next entry in the man's medical record is later that month, and reads, "did not attend sick parade, out on exercise". The next entry, nearly a month later, shows, "did not attend". The clinical reviewer notes that it is not apparent what concerned the man at this time.
13. The following year, in February 2005, the man was transferred to HMP Parkhurst and his medical notes record that he was "fit for transfer". The entry on the next day, states that he was transferred from HMP Wandsworth as an enhanced prisoner with no medical problems, and who described himself as fit and well. There are no further entries in the man's medical file until the day he collapsed.
14. The man's personal record shows that he completed an induction interview and was allocated to B2 landing in cell 7. A further entry in this record advises that regular entries should be made by the man's personal officer. There are then several entries in this file each month. The comments are general, for example describing him as a "quiet man who keeps himself to himself", "does not mix a lot on the wing" and "attends work regularly".
15. A fellow prisoner said that he had known the man for quite a few months since he moved to Parkhurst from Wandsworth. He explained that they first got talking as he was showing him how to use the washing machine. He subsequently helped the man get to grips with the prison's rules to help him settle in. They spent some time together when they were both on B wing, but then the man moved to G wing and they did not see each other very often. Some weeks later, they both moved to C wing and became good friends, even though he was a lot younger than the man who died. They were joined about six weeks later by a friend of the man's from a previous wing.
16. The three men became very close. The younger friend said they "talked about everything" and looked out for each other. He said the man spent

a lot of time talking about his legal case. They soon developed a routine of cooking together on a Saturday when they would pool their canteen supplies and make carrot juice, a cake and an evening meal. The younger friend explained that each Saturday morning, after breakfast, the man would come to his cell to start their preparations.

17. On the Saturday the man collapsed, he left his cell on the first landing as usual after breakfast and went to his younger friend's cell on the '3s' landing. His younger friend said that he seemed his normal self, and they prepared the juice and cake. They had also prepared a dish which they intended to eat later that day. At lunchtime, about 12 noon, all three had their lunch from the servery and said they would see each other later. When they were unlocked later that afternoon, the man and his younger friend went to the kitchen to cook their evening meal.
18. The younger friend explained that, between 4.00pm and 5.00pm, he and the man returned to the kitchen, collected their food and took it back to his cell to share out and eat with their other friend. When they arrived back at the cell, their friend was already there. At this time the servery was serving the evening meal and, although they were going to eat their own food, the older friend asked if anyone wanted a juice or dessert from the servery. The others declined and the older friend went down to fetch a drink for himself.
19. As he started to serve their meal, the younger friend said the man spoke about how stressed he was and suddenly said that he could not take any more. At this point, the younger friend said he looked up and saw the man fall backwards. He tried to grab his waist and his arms but could not, and the man's glasses came off as he fell to the ground. The younger friend said he did not know what was happening. He could see the man's eyes roll back and he was gasping for breath. He described how the man appeared to grab for his glasses, but in hindsight thought that perhaps he was grabbing his heart as he thought he was fainting.
20. The younger friend said that his first reaction was to get some water and fan the man with a towel. He explained that at this point the man's older friend returned to the cell and began to ask what had happened. The younger friend told him that he did not know, and asked him to continue fanning the man whilst he called an officer to help.
21. The older friend said that he was in the man's younger friend's cell, talking while the cooking was finished. He decided to go to the servery to get some drinks. When he returned, he saw the man was on the floor and asked the younger friend what had happened. He said that he was told that the man had just collapsed, and went on to say that he thought that the younger friend seemed afraid and did not give him a clear explanation about what had happened. He had urged the older friend to fan him and put some water on the back of his head, while he started calling for an officer.

22. When the younger friend put his head out of the cell, he said he saw an officer at the end of the landing, about 10 to 15 cells away, and called him to his cell. He said that the officer did not respond, and he did not know if he had heard him or not. It was nearly time for the prisoners to be locked up, and the younger friend explained that there were lots of prisoners running about and so it was very noisy.
23. As the officer did not respond, he decided to press the call bell to make him react faster and realise something was going on in the cell. The officer then started to run towards the cell, and he told him that his friend had collapsed. The officer opened the door and saw that the man was slumped against the back wall. He asked the younger prisoner what he had been doing and he described how the man had collapsed and that he and the older friend had fanned him with a towel and sprinkled some cold water on him.
24. The older friend reiterated that he did not get a good description about what had happened. The younger friend had just told him that the man had collapsed and he went to the landing, called the officer and returned to the cell. The older friend described the younger friend as very upset, saying the officer was taking too much time as he was walking when he should be running. Eventually, the younger friend rang the call bell and the officer came into the cell.
25. The landing officer said he was on the 3's landing at about 4.50pm when the younger friend shouted and beckoned him to his cell, number 98, on the third landing. The landing officer did not think that the younger prisoner seemed unduly worried, and had not called out that he needed help or that it was an emergency. He said that he had called "Gov" twice and pointed to his cell, which the landing officer thought was because the cell doors frequently slammed shut in the wind and staff are often asked to unlock them. As he approached, the younger prisoner then rang the cell bell and that was when he thought that "something serious" was going on and began to sprint. When the landing officer entered the cell, he saw the man collapsed on the floor and the older prisoner told him that they could not get a response from him.
26. The older prisoner said that when the officer entered the cell he saw the man on the floor and used his radio to call an alarm. He then said two other officers rushed into the cell followed by the senior officer. He said that the way the man had fallen made it difficult for him to breathe. He described his head as resting on the heating pipe that runs along the wall, about ten inches from the floor, with the rest of his body on the floor.
27. The landing officer explained that the 2's landing officer arrived at the cell soon after him and they both tried to get a response from the man by calling his name. The younger friend said that the second officer

arrived within one and a half to two minutes of the call bell. He asked him not to let anyone else into the cell, as by then all the prisoners had heard the emergency call bell and were gathering around the door. Other officers had also heard the call bell and began to arrive at the cell.

28. The 2's landing officer said he was patrolling his landing on C wing, when he heard the alarm bell sound and immediately made his way to the 3's landing. He said that, as he approached the cell, there seemed to be an incident of some kind. When he went in, he found the younger prisoner, the older prisoner and the landing officer. He described the man as slumped against the back wall of the cell in a sitting position. The younger prisoner told him that the man had collapsed.
29. The younger prison said that by then the senior officer had entered the cell, been told what had happened and called for medical assistance. According to the younger prisoner, they then waited for a doctor to arrive. He said he was getting angry at what seemed to be a delay. He also said that he and the older prisoner were upset, but did not want to leave the cell as they wanted to know what had happened to their friend. The younger prisoner said the senior officer looked at him, saw his reaction and asked what he should do. He said he was angry, but knew that first aid should be started and began to administer mouth to mouth resuscitation himself.
30. When the senior officer and a female officer arrived, all four members of staff lifted the man onto the bed and placed him in the recovery position. The landing officer said he felt for a pulse, but could not find one. At the same time, he said the female officer moved the man into a position to enable CPR to be carried out. He explained that she began mouth to mouth resuscitations, while the senior officer started administering chest compressions. The younger prisoner said that the senior officer asked whether any of the officers knew how to do first aid, and the female officer confirmed that she did, after which the senior officer told him to get up as the officer would take over.
31. The female officer said she was on G wing on the 2's landing when she heard an alarm bell call from C wing on the radio. She explained that there is a connecting door from G2 landing which takes you through to C1 landing. She said that, as she arrived on C2, she was directed by prisoners onto the 3's landing and into cell 98. She estimated it had taken her no more that 60 seconds from hearing the alarm to entering the cell. She explained that inside the cell were the younger prisoner, the older prisoner, 3's landing officer, the wing officer and the 2's landing officer. She said that the 3's landing officer and the 2's landing officer were fanning the man, who was slumped against the back wall, and were trying to get a reaction from him by slapping his face. She told them to stop in case the man had any neck or head injuries. They believed he had a gold tooth and they were trying to remove this before attempting CPR.

32. The female officer said that together the officers lifted the man onto the bed. She said the senior officer asked who was a first aider, and she replied that she was and started to check for a pulse. She said she called out that no pulse could be detected and shouted for a face mask. In interview, she said that the staff agreed that they could not wait for a mask whilst the man was not breathing. She started to move him into the recovery position and she and the senior officer, who by now had arrived at the cell, started CPR. She started mouth to mouth without the mask, with the senior officer giving chest compressions. She said they went through this process twice and then the healthcare officer relieved her. She said she stayed in the cell in case the senior officer needed a break. She said a prison service nurse, also from healthcare, then arrived and let them know that the defibrillator was on its way.
33. As other officers arrived, the 2's landing officer said they lifted the man up onto the bed and, when they failed to locate a pulse, they informed the principal officer who had just arrived. The 2's landing officer said principal officer then contacted the control room by radio, informing them that an ambulance should be called and that healthcare staff were required. He explained that, following the first set of chest compressions, he checked for a pulse again but was unsuccessful. They continued with CPR until healthcare staff arrived a few minutes later and took over. The senior officer estimated that it was about five minutes later when the healthcare staff arrived and took over the resuscitation. The female said they continued to attempt CPR until the healthcare officer arrived and took over, she estimated this was at about 4.54pm. At this point, she explained, both she and the landing officer left the cell and had no further involvement. The 2's landing officer said he also left the cell, but later helped the ambulance crew carry the man onto the landing, and later still helped get him into the ambulance.
34. According to the healthcare officer, the alarm bell for C wing rang at approximately 4.51pm asking for healthcare staff to attend the wing. He said he used his radio to ask whether blood or oxygen was required so he could decide which emergency bag to take. He said that, virtually at the same time, he heard the senior officer issue the instruction to get healthcare staff, and so he grabbed both bags and ran. At that time his colleague, was returning from administering treatments and they went together to the wing and up onto the 3's landing.
35. When the healthcare officers arrived at the cell, they found the senior officer and the female officer administering CPR. The healthcare officer told them that they would take over and he took over chest compressions, whilst his colleague used the Ambu bag to administer oxygen. An 'Injury to Prisoner' form was completed when the man collapsed. This shows that healthcare staff were contacted at 4.54pm and the duty Governor was contacted at the same time. Also at this time, an ambulance was called.

36. The healthcare worker explained that a second senior officer then arrived with the defibrillator machine which he wired up and instructed him to administer electric shocks to the man. He said that the ambulance crew then arrived, by which time the man appeared to have regained some colour. The ambulance crew moved the man off the bed and onto the landing floor in order to have more space to work. The healthcare worker continued CPR while the ambulance crew administered medications, and continued to shock the man.
37. The healthcare worker explained the weekend healthcare arrangements at Parkhurst. There are two workers on the clinics which are the outpatients department for the whole prison. There is also an in-patients department with an additional three or four members of staff. There is no doctor on site on Saturday but they are called in to attend, when necessary.
38. The second senior officer said he arrived on C wing at 4.57pm. He was told by a prison service nurse that a prisoner had no pulse and was not breathing. On the way he collected the defibrillator from E3. He pointed out that he had not been carrying a radio that day and so only heard about the alarm through another member of staff (I return to this issue later). When he came into the cell he saw the man on the bed. The healthcare worker was administering chest compressions while his colleague was giving breaths. He said a prison service nurse was also there, having brought oxygen from E3.
39. The prison service nurse explained that she was Radio Call Sign Hotel 1 that day. This meant she was the nurse designated to respond to any emergency situation. She said she received the call asking for hospital staff to attend an unconscious person on the wing. She heard on the radio that the person had stopped breathing, so she picked up the oxygen. When she arrived at the cell she said the healthcare worker was already there doing chest compressions and someone else was giving breaths. She said the ambulance had already been called. She explained that, by the time the paramedics arrived, the defibrillator had already been connected and had directed them to shock the man twice - which they had done.
40. The second senior officer to attend the cell said he applied the defibrillator pads and the machine advised him to shock the man, which he did. He said CPR was restarted, until the machine advised that another shock should be given. Again CPR was continued until the paramedics arrived. They then took control of the man's care and instructed the healthcare worker to continue giving rescue breaths. They directed the healthcare worker and the second senior officer to alternate giving external cardiac compressions. The second senior officer said that three doses of drugs were administered and the paramedics shocked the man two or three more times.

41. The younger friend said he remained angry with the situation and eventually he got up and stood by the door to allow the other officers to get inside. He and the older prisoner then left and did not see what else happened in the cell. Whilst waiting outside, he said that the female officer came out and was upset. By this time, the younger prisoner said that he and the older prisoner were extremely upset, and he asked the officers to tell them whether the man was still breathing. He said that the officers could not tell them anything, but brought chairs for them to sit down and then encouraged them to go to the older prisoners' cell together. The older prisoner estimated that the ambulance arrived about five or six minutes later.
42. The Prison Service nurse remembered that the ambulance arrived very quickly. She said the man was breathing with oxygen when he left in the ambulance. Before he left, she went to get his medical record to see if he had a treatment card, which he did not.
43. Records show that another senior officer arranged for all the prison gates to be opened to allow the ambulance clear access. The ambulance arrived at the prison gate at 4.57pm and the paramedics were on C wing at 4.59pm. The doctor was called to the prison at 5.14pm. Records also show that the security department, reception and the hospital were contacted at 5.25pm to make arrangements for the man to be moved there. The ambulance left the prison at 5.30pm.

After the man went to hospital

44. At 6.20pm, a member of the care team, a support service for staff, was asked to come into the prison. The Independent Monitoring Board (IMB) were notified at 6:32pm. The man's family were also contacted that evening and told that he had been taken to hospital. Some of them travelled to see him that night.
45. Later that evening, the younger prisoner said that a member of staff whom he did not know approached him and the older prisoner and said that the hospital had informed them that the man had overdosed. According to the younger, he asked whether the man had taken any drugs or alcohol. The younger prisoner said that both he and the older prisoner were certain that the man had not taken either and they told the officer this.
46. The officer said he would relay that information to the hospital. The younger prisoner said throughout the night other officers spoke to them saying that the man was recovering, was pulling through, but was "on a machine". The younger prisoner said at this time he knew from a secret source that the man had had another heart attack, and had not been informed by prison staff even though he was a close friend. After getting the information, the younger prisoner said he approached a member of staff to ask why he had not been told, and was informed that staff were also unaware of it.
47. About two days later, the younger prisoner said that another member of staff approached him to ask if he wanted to see the chaplain or speak to a Listener. The younger prisoner said that for three nights he and the older prisoner stayed together in his cell on the 2's landing. On the first night, he said that an officer left their door open and stayed with them for three hours to see how they were.
48. He then was moved over to F wing and found it even more difficult to obtain information about the man. When he did make enquiries of the staff, he said they said that nothing had changed and he learnt of the man's death through his secret contact. He commented that he had not found the officers very caring, and compared them with others he had met in other prisons. The older prisoner said he was not told about the man's death, but saw a notice on the board announcing his death. He said he was very upset and went to the senior officer to say so. He said the senior officer replied that everyone had the right to know at the same time, but the older prisoner said that he and the younger prisoner were not the same as other prisoners, but were like a family.
49. The older prisoner said he and the younger prisoner planned a memorial service together. He described the man as a great friend - one who would put his own worries aside and take care of someone else and was like a father to him.

50. While the man was in hospital, a Release on Temporary Licence (ROTL) Board was convened at Parkhurst. This was attended by a governor and the Head of Resettlement. It was decided that, following a risk assessment under the terms of Governor's Instruction 36/1995, the man was eligible for temporary release on compassionate grounds. This meant that the man would not require the supervision of staff and would not be handcuffed during his stay in hospital. It was decided that the man's situation would be reviewed by the head of security on a daily basis. A week later, the ROTL conditions were reviewed and it was decided to continue with the agreed arrangements.
51. The man did not regain consciousness and died in mid August. At 9.00pm, the duty governor was informed by the control room at Parkhurst that the man had died at 8.45pm. At 9.10pm, he confirmed the death with the night sister at the hospital. At 9.15pm, he contacted the man's mother and brother to inform them of the death. The control room then contacted the police and requested that they inform the Coroner.
52. At 10.00am the next day, the family were contacted again and it was arranged that the man's brother, would travel that day to identify the body. The bed manager at the hospital was also contacted and asked to meet the man's brother.
53. The then Governor, wrote to the Coroner's office, formally notifying him of the man's death. He said that the man had had a heart attack and had been taken to the local hospital by ambulance. He had been treated in the Intensive Care Unit. The governor confirmed that he had released the man on temporary licence. He also mentioned that security information had been received to indicate that the man might have been assaulted before his death. He said this information had been passed to both the hospital and the police. He confirmed that he had secured all of the man's records should they be required. This is another issue to which I shall return.
54. Later that month, the governor wrote to the man's mother properly offering condolences following the death of her son. He explained the procedures that would follow, including an inquest and my investigation. He also invited the family to visit the prison if they wished and confirmed they would keep the man's possessions safe until they were ready to receive them. He provided the man's mother with the contact details of the Family Liaison Officer (FLO) and confirmed that the family could contact him or the FLO at any time.
55. I have considered these actions in the light of Prison Service Order 2710: Follow up to deaths in custody, which provides detailed instructions of the actions required following any death in custody. I consider that all the instructions were followed appropriately in this case.

56. The same day, a post mortem was conducted. The pathologist concluded that the man had suffered a heart attack. He reported that the man's heart had stopped beating for a period of time and his brain suffered severe and irreversible damage due to oxygen starvation. Despite resuscitation and other continuing supportive measures, there was no improvement in his condition and he subsequently died. There was no autopsy evidence to suggest that he had suffered violence prior to his death. For recording purposes the cause of death was given as:

- 1a Hypoxia brain injury (brain injury as a result of a lack of oxygen)
- 1b Myocardial infarction (heart attack)
- 1c Coronary artery thrombosis (fatty narrowing of the arteries supplying the heart muscle).

Issues considered during the investigation

The man's clinical care

57. The clinical reviewer says that the man had little contact with medical services in prison, having been found fit and well on reception at Wandsworth. He was also found to be fit and well when he transferred to Parkhurst. The clinical reviewer observes that it is not clear why the man completed a healthcare application form in 2004. It seems that he did not complete any subsequent applications and did not raise any issues when he was transferred to Parkhurst, where he would have had the opportunity to see a member of staff - usually a nurse, on a first night health screen. He would also have had the opportunity to see a doctor if he needed to do so.
58. In the opinion of the clinical reviewer, the man's medical care was equivalent to that he was likely to have received in the community and he appears to have received urgent attention when he was found collapsed. His only comment is that, in the long term, prison medical services should be undertaking more Well Man clinics including the recording of individual's smoking status, offering stop smoking advice and recording blood pressure.

Healthcare at Parkhurst should consider undertaking more Well Man clinics.

The prison's response to the man's collapse

59. The man collapsed suddenly and unexpectedly. My investigator has spoken at length to his friends, and to several members of staff. From these interviews, it is clear that there was a certain level of panic in the cell. Not surprisingly, the man's close friends were both upset and troubled.
60. CPR was first attempted whilst the man was lying on a bed. This contravenes the instructions in PSO 2700 (annex c) which say that CPR should be administered on a hard surface such as a floor. The clinical reviewer makes no comment and I am satisfied that it did not affect the outcome for the man. However, staff should be reminded of the terms of the PSO.

Staff should be reminded that it is best practice for CPR to be administered on a hard surface and not a bed.

61. The man's younger friend said that he was both angry and upset at the delay in the landing officer's response to his request for help. However, he also conceded that at the time the wing was busy and noisy and it would have been difficult for the landing officer to have heard his calling above the noise. Moreover, within two minutes of him pressing his call bell there were eight members of staff in and outside the cell.

62. Both the landing officers were in the cell when the female officer arrived but had not started to administer CPR. When questioned why this had happened, the female officer explained that when she arrived they were fanning the man with a towel. They believed he had a gold tooth and they were trying to remove this before attempting CPR.

63. In an ideal situation, if the landing officer had heard the younger prisoner's call he might have attended the cell slightly earlier. Perhaps if the cell call bell had been used earlier again the officer might have attended sooner. However, I am satisfied that staff attended promptly when the bell was rung and that there was no delay in their response. I am equally reassured that CPR was started as soon as was possible, whilst ensuring that the man's care and safety was preserved. I do not share the younger prisoner's claim that staff "did not seem to care".

Did the younger prisoner attempt CPR?

64. In his discussion with the investigator, the younger prisoner said that he instigated the CPR proceedings as staff did not seem to be taking any action. However, the senior officer is adamant that this did not happen. Additionally, he is definite that the comments attributed to him by the younger prisoner were not said. He is clear that, as soon as staff assessed the situation and moved the man up onto the bed, he and the female officer began CPR. He is unambiguous about the fact that this was the first attempt at CPR.

65. The landing officer and the other staff members who attended the man's cell agreed with the senior officer's account. I have found no further evidence to support the younger prisoner's description of events.

Was the man attacked?

66. There was some concern expressed by the staff interviewed during this investigation that the man had been attacked. From the documents reviewed, it is clear that management at Parkhurst had been made aware of these concerns and acted appropriately in passing on the information. Hospital staff were informed, but subsequent checks found no evidence that the man had been attacked or had been involved in a struggle. This information was also passed to the police who conducted their own enquiries and again found nothing to support this assertion.

67. I am satisfied that no evidence has come to light to support the concern expressed by staff.

Bedwatch arrangements

68. I am pleased to say that the man's ROTL arrangements were well handled. The decision not to use restraints was entirely appropriate

given the circumstances. I believe the Governor made a correct and timely decision, and commend him for it.

How staff and prisoners were informed of the man's death

69. As this investigation unfolded, it became clear that one area of concern for staff and prisoners alike was that they were not kept up to date about the man's condition, and felt they were not informed of his death appropriately when he died. It was particularly upsetting for the man's friends, who quite rightly felt that they deserved to be told in a more sensitive way and certainly not by way of a general notice.

70. Equally, for staff involved in the man's resuscitation I do not think a personal telephone call or visit from a governor is too much to ask. I know some of the staff involved visited the man in hospital of their own volition to check on his progress. Others volunteered for bed watch duties in order that they could visit him. It appears that staff members found out from colleagues or notices placed around the prison. The majority of staff felt this was rather a wretched way to learn of the man's death, in addition to not receiving any updates on his prognosis. I agree with the views of the staff and prisoners involved and believe a review of the arrangements should be undertaken.

The Governor should take steps to ensure that the local Death in Custody policy is reviewed, in particular ensuring there is sensitive and appropriate communication of such news with staff and prisoners.

Contact with the man's family

71. The man's family were informed quickly after he collapsed and subsequently several members of the family were able to visit him at hospital.

72. Although no members of prison staff attended the funeral, a memorial service did take place at Parkhurst and several members of the family were able to attend. The family were happy that they had been treated properly by the prison and particularly mentioned the chaplain as someone who had been helpful.

First Aid & CPR Training

73. Although not pertinent to the man's death, this investigation did identify an area of concern regarding training in first aid and the use of the defibrillator, and the deployment of those trained staff.

74. The second senior officer who responded to the alarm and the healthcare nurse had been trained by the St. John's Ambulance Brigade. They are both first aid and Use of Defibrillator trainers, which means they train other staff within the prison as well as prisoners. At the time of the man's collapse, they were the only two members of staff

in the prison trained to use the machine. The senior officer pointed out that, despite his qualification, his duties that day did not require him to carry a radio and so he did not hear the emergency call. He was informed of the man's collapse by another staff member who happened to pass him as she was on her way to the cell.

75. It also became clear during this investigation that several members of healthcare are not first aid or Defibrillator trained. It must be questioned why staff members with key skills were not asked to attend the emergency, and whether healthcare staff are the best people to contact in such emergencies. I make no judgement either way, save to say it is an area the Governor should consider, in consultation with both healthcare and the relevant members of non-medical staff.

The Governor should undertake a review of emergency response systems within the prison, ensuring the most appropriate staff are contacted in such emergencies.

76. The landing officer said that he had been first aid trained some four years ago and had not had the opportunity to undergo a refresher course since. He believed, as other staff did, that a refresher course should be available once a year. He was clear that he did not feel competent in attempting resuscitation without up to date training.
77. The second senior officer and the healthcare nurse have dedicated much of their own time to undertake courses and gain qualifications in order to train other staff and prisoners at Parkhurst. At present, there are 35 members of staff trained in first aid at Work, 37 staff trained in Emergency Aid and 14 staff who are defibrillator trained. It is important that such staff are properly supported and resourced to enable them to continue the work they do.

The prison should undertake a review of the first aid, emergency aid and defibrillator training to ensure staff have regular access to refresher training.

Response to the PPO investigation

78. My conclusions about the man's care at Parkhurst are almost entirely positive. All those interviewed have impressed as professional and decent members of staff. However, unusually, I have very real reservations about how the prison organised its liaison with my investigation.
79. Initially, my investigator was allocated an officer to act as her point of liaison. He was frank about his lack of training, but said he was keen to learn and be as helpful as he could. A few days later, the investigator was contacted by another member of staff who also believed that he was to be the liaison officer. This person had been trained as a family liaison officer and was indeed working with the man's family as their

contact. Some days further on, he spoke to the investigator again and said he had made a mistake and was not to be the liaison. The investigator then contacted the prison and was told that a governor would be the liaison, and indeed was so until the investigator made her first visit. Thereafter, the investigator was told to use a member of the support staff as her contact.

80. Again, this person tried to be as helpful as possible but she did not have any training or resources to carry out the role. Additionally, although it should not be so, she had no authority to release officers from their duties to attend interviews. As a consequence, my investigator arrived at the prison on a number of occasions to interview staff only for people to fail to attend, or to arrive but not be prepared to proceed with the interviews. The staff members explained that they had not been given notice of the interviews, and therefore could not arrange representation to accompany them or indeed prepare themselves to be questioned. This resulted in the investigator having to return several times to Parkhurst to complete interviews which would usually have taken a day or two.
81. Overall, this suggested a lack of management interest in my investigation, something that was quickly picked up by the staff who were interviewed.
82. As liaison was given insufficient priority, it contributed in some part to the delay in the production of this report. However, following the appointment of a new governing Governor, I am pleased to say the liaison procedures improved significantly allowing the investigation to be completed more effectively.

Conclusions

83. The man's collapse was sudden and unexpected. He had not reported any illness to healthcare staff at Parkhurst or complained to staff or friends of feeling unwell. Staff responded promptly and professionally when the alarm was raised and did all they could to aid him. The ambulance was called promptly and arrived swiftly and he was taken quickly to the local hospital.
84. I am satisfied with the way the man was cared for at Parkhurst. His family did raise some concerns when initially contacted by my family liaison officer, and were worried that the man had not been attended to quickly when he was taken ill. I hope that this report has answered their questions and met their concerns.

Recommendations

1. Healthcare at Parkhurst should consider undertaking more Well Man clinics.
2. Staff should be reminded that it is best practice for CPR to be administered on a hard surface and not a bed.
3. The Governor should take steps to ensure that the local Death in Custody policy is reviewed, in particular ensuring there is sensitive and appropriate communication of such news with staff and prisoners.
4. The Governor should undertake a review of emergency response systems within the prison, ensuring the most appropriate staff are contacted in such emergencies.
5. The prison should undertake a review of the first aid, emergency aid and defibrillator training to ensure staff have regular access to refresher training.

Having read a draft copy of this report the Prison Service have accepted all of the recommendations made.

Good Practice

- The Governor should commend the initiative of the staff members who have obtained first aid qualifications in their own time and used them to train colleagues.