Investigation into the circumstances surrounding the death of a man at HMP Garth in September 2006

Report by the Prisons and Probation Ombudsman for England and Wales

October 2007

This is an investigation into the circumstances surrounding the death of a man on 21 September 2006. The man collapsed in his cell at HMP Garth in the early hours of the morning and died shortly afterwards. He was 49 years old.

I extend my condolences to the man's family and to all those touched by his death.

The investigation was undertaken by my colleague. Both my colleague and I would like to extend our thanks to the Governor of HMP Garth, and her staff for their cooperation during the investigation. Particular thanks go to the appointed prison liaison officer, for gathering all relevant documentation and ensuring it was made available in a timely way. I would also like to thank the prisoners on the man's wing for responding to the notice of the investigation.

The Central Lancashire Primary Care Trust (PCT) carried out a clinical review into the healthcare the man received at HMP Garth. I am most grateful to the clinical reviewer for completing the review so speedily and for the recommendations drawn from her findings.

The man was a life sentence prisoner who had spent a total of 14 years in prison when he died. He transferred to Garth in September 2001 and was described by both staff and prisoners as a man in poor health who kept himself to himself. He was a trusted prisoner who did not mix with the wider prison population and served his sentence quietly.

He had a history of high blood pressure and heart problems. He was a reluctant patient and refused medication designed to lower his blood pressure on many occasions. I am in no doubt that healthcare staff did all they could to encourage him to take his medication and to accept the medical treatment offered to him.

I also commend Garth for the immediate and sustained action that staff took in response to his sudden death. I make particular reference to two members of staff for the exhaustive first aid response they administered, and to the way the Governor and staff managed both the prisoners and the family's needs after he died. I have highlighted these and other actions as examples of good practice. I am also grateful to Garth for the high standard to which his prison records were completed and then produced for my investigator's use.

Although there are some lessons to be learned, this is a report that reflects very, very well on Garth, its managers and staff.

Stephen Shaw CBE
Prisons and Probation Ombudsman **October 2007**

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SUMMARY

The man had a history of heart problems and needed medication to regulate his blood pressure throughout his time in prison. He consistently refused treatment and was reluctant to take his prescribed medication, often saying that it did not work. Despite the best efforts of healthcare staff to persuade him otherwise, he continued to refuse medication or at best to use it only sporadically.

He was a quiet and trusted life sentence prisoner at HMP Garth. He was employed as a dining hall cleaner and only came to the attention of prison staff when his heart condition worsened and his blood pressure needed managing. He was a reclusive man, who readily accepted the consequences of his offence, and quietly served his sentence.

At 1.49am on Thursday 21 September 2006, he pressed his cell bell. He was found in a collapsed state on the floor of his cell by a night duty officer. He was given emergency first aid until paramedics arrived. Despite the best efforts of healthcare staff and the officers on duty that night, he never regained consciousness and died shortly afterwards. He had served 14 years in prison and was aged 49 at the time of his death.

Because he died during the night, the prison's staffing level was at its minimum. However, this night patrol state did not hinder Garth's attempts to respond to the emergency. Staff showed their ability to work together as a team in response to an unforeseen circumstance, whilst at the same time maintaining both the security of the prison and the wellbeing of the other prisoners on the man's wing.

Security is inevitably compromised when a prison faces an emergency. Local guidance on the balance to be struck between maintaining a safe and secure environment, whilst making every effort to preserve life, could be made clearer to staff. In this man's case, immediate entry into the cell would not have saved his life. That said, my investigation has highlighted the need to remove any confusion or uncertainty from local instructions, and to encourage staff to make a reasoned judgement about an emergency situation before entering a cell.

THE INVESTIGATION PROCESS

1. The investigation was opened on 25 September 2006. My investigator began by requesting all relevant prison records relating to the man. These included his medical and core records covering the 14 years he spent in prison.

2. Notices to staff and prisoners were supplied and displayed around HMP Garth. These invited anybody with information to talk to my investigator. One prisoner came forward and provided information on behalf of a number of prisoners who knew him. My investigator examined the records and recorded significant events before visiting the prison. Using the evidence gathered from his records, she identified a number of key prison staff. She interviewed four uniformed staff and one nurse from the healthcare team in November 2006.

3. The Central Lancashire Primary Care Trust (PCT) was invited to undertake a review of the clinical care the man received while in custody. The clinical review is included as an annex to this report.

4. The Coroner was informed of the Ombudsman's investigation. The post mortem report concluded the cause of death as:

   1a Aortic dissection with rupture to haemothorax

   The Coroner will receive a copy of this report when it is completed to assist him with his enquiries.

5. One of my Family Liaison Officers, contacted the man's family to discuss the purpose of the investigation, and to offer them the opportunity to raise any concerns or questions about his time in prison. The man's family have maintained regular contact with my office and have been interested to learn the findings from my report. I hope the report is helpful to them in understanding the events leading up to his death.

HMP GARTH

6. HMP Garth, near Preston, is an adult male category B training prison. It is a purpose built establishment that sits alongside HMP Wymott on the site of a former Royal Ordnance factory. Garth currently has an operational capacity of 667.

7. Accommodation at Garth consists of five residential units, A to E, most with dual purposes. A wing is partly used as a first night centre and induction wing with part of B wing used to house vulnerable prisoners. Mandatory drug testing (MDT) is carried out on C wing. Prisoners on all wings are subject to MDT. E wing also provides a therapeutic community setting and I wing, renamed the Care and Control Centre (CCC), is for segregated prisoners. Work is in progress to build a new residential wing due for completion in late 2007.

8. The healthcare centre consists of a primary care service and 24 hour inpatient care with eight beds. Nurse-led clinics, including a heart disease management clinic, are in operation. Prisoners are called to attend for regular check ups with in-house nursing staff or visiting specialists.

9. The most recent report of a full announced inspection by Her Majesty's Chief inspector of Prisons (HMCIP) was published in 2004. Inspectors found Garth to be a safe, respectful and improving prison with solid relations between prison staff and prisoners. The report congratulated Garth for securing an environment that placed emphasis on purposeful activity, including work, education and training, for some of the most challenging and long term prisoners.

10. For life sentence prisoners, HMCIP found that life sentence plans, were "surprisingly poor and needed to be improved". However, the Chief Inspector, of Prisons commented favourably on the policy to locate prisoners across all wings. This resulted in a small number of 'lifers' on each, with a dedicated staff and a lifer governor to oversee their specific management across the whole prison. Prisoners told inspectors that they were treated well due to the accessibility and helpfulness of staff.

11. HMCIP found that healthcare services had improved since the last inspection in 2001, and that a good working relationship had developed between Chorley and South Ribble Primary Care Trust (PCT) and Garth's healthcare centre. Healthcare staff were found to be highly qualified and annually trained in resuscitation. HMCIP reported that training was carried out in-house by two members of staff who were Resuscitation Council (UK) trained advanced life support officers. The pre-inspection prisoner survey results indicated that prisoners felt healthcare provision was good or very good, especially nurse-led healthcare. This placed Garth above the average when compared to similar establishments.

KEY FINDINGS

12. The man was transferred to HMP Garth in September 2001. Healthcare staff knew from his medical records that he had been previously monitored for high blood pressure (BP). For his first 18 months at Garth, he was treated for migraine and prescribed pain killers.

13. He came to the attention of healthcare staff again in June 2003, complaining of chest pains. He was seen by the prison doctor and referred to Chorley Hospital, where he was diagnosed with an aortic aneurysm (a swelling of the largest artery in the heart). His BP was placed under control, but he discharged himself from hospital two weeks later against the advice of the doctors treating him.

14. A year later, in May 2004, healthcare staff noticed that he was not regularly taking his medication. He admitted that he did not like taking so many tablets, and felt well enough. However, he did agree to make more of an effort to take his medication in future. Nevertheless, in February 2005 healthcare staff again noticed he had neglected to take his medication.

15. A review of the man's heart condition took place in June 2006. At the review, he said that he was fully aware of the consequences of not taking his prescription, and had already been told of the potential danger to his health if he continued to refuse medication. He repeated that he did not like taking lots of tablets. He also said he felt they did not make him feel any better. After the review, his BP was taken and recorded. Healthcare staff told him he needed to see the prison doctor to discuss his condition. He declined to make an appointment.

16. Throughout July 2006, his condition was checked and monitored by healthcare staff. The medical record showed that his BP was high and that he had remained non-compliant with his medication. On 21 July, his BP was taken again and revealed no change. The man said he had taken a few tablets the previous week to help lower his BP and agreed to return to healthcare for more checks. There is no evidence that he did in fact return to healthcare after this date.

17. On the evening of 20 September, he was locked behind his cell door on A wing for the night. The night officer for A wing, started his shift at approximately 8.00pm and carried out his routine checks and patrol of the landings.

18. At 1.49am on 21 September, the officer noticed that the man had pressed his cell bell on the third landing. On arriving at the cell, the officer looked through the observation panel and saw him lying motionless on the floor under a small table. The officer called the man's name and knocked on the cell door, but failed to get a response. The officer made his way to the office, approximately one minute's walk away, and rang Communications to ask for assistance from Oscars 1, 2, 3 and Hotel 1. (Oscar 1 is the code used for the night orderly officer in charge of the prison. Oscars 2 and 3 are interventions officers,

detailed to respond to any situation throughout the night. Hotel 1 is the name given to the night duty nurse, responsible for attending any medical emergency.)

19. The same officer immediately returned to the man's cell and tried to get his attention again from outside the cell door. When he failed to get a response a second time, he made his way downstairs and waited for the officers and nurse to enter the wing.

20. A Senior Officer (SO), who was Orderly Officer for the night, was in the healthcare unit when he heard an announcement over his radio that assistance was required on A wing. At the same time, a nurse, the only nurse on duty that night, also received a call over her radio to contact 'security'. The nurse told my investigator that the internal telephone rang and she knew then that it was an emergency. She said:

> "They [security] said I needed to attend A wing, we have a collapse. So as soon as they said a collapse I took all the equipment."

The nurse explained to my investigator that, on a night shift, the nurse responsible for attending emergencies does not carry keys to the establishment and needs to be escorted to an incident by the key holder. As the SO, the main key holder, was already in healthcare, they immediately made their way to the man's cell together.

21. The nurse picked up the emergency bag which is held in the healthcare unit, while the SO began to unlock each gate en route to the man's cell. The nurse told my investigator that Garth's healthcare unit has emergency bags prepared and fully equipped for every medical emergency. The nurse explained that there is an emergency bag for attending to incidents of self harm which carries different equipment to the emergency bag for a collapse. The nurse further explained that, because it had been made clear to her over the radio that the emergency was due to a collapse, she was able to pick up the emergency bag specifically tailored to respond to that type of incident and had all the equipment she needed.

22. The interventions officers for the night were carrying out their own duties on C and D wings when they were told over the radio to make their way to A wing. On of the officers told my investigator:

> "We got radioed at about 1.55am to go to A wing, but you know we always get radioed throughout the night to such a place so it was nothing untoward really. It just said go to A wing, so I just went straight there and I met the officer who was on duty on A wing, I can't remember his name, he said somebody had collapsed on the threes [third landing], and I was the first officer, well first intervention officer to have arrived onto A wing, but followed straightaway by the other intervention team. So that's obviously what I went on, initially he said somebody had collapsed so that's my first recollection."

23. Both officers waited outside the man's cell on the third landing with the A wing officer. The SO and the nurse arrived almost immediately after them. Reflecting on his response to the alarm, the SO told my investigator:

> "We managed to get into the cell at about 01.54. It took about two maybe three minutes maximum which given the length of the distances that we've got to run, from one end of the jail to the other, that's quite a speedy response."

On arrival, the SO unlocked the cell and all five members of staff present entered. When interviewed, he recalled that both interventions Officers immediately re-positioned the man on the floor so that the nurse could begin Cardio Pulmonary Resuscitation (CPR) easily. The SO then asked one of the officers to start a log of events.

24. The nurse could not find a pulse or any sign of breathing and recalled that the man appeared pale and lifeless. The nurse immediately began chest compressions while an officer opened the man's airway, using a tube from the emergency bag, to administer mouth to mouth resuscitation. The nurse asked for an ambulance and the SO instructed the control room, via his radio, to call the emergency services. He told my investigator:

> "It was quite, quite apparent right from the start that we weren't getting any chest movements on his chest. He had a little bit initially at the beginning but not what you would normally associate when you are trying to pump air into somebody's lungs and [the officer] was getting, it was really getting difficult. So clearly we had a major problem on our hands so I instructed, I forget the time, I think it was within a couple of minutes, I instructed Control to contact the ambulance on 999 and get the ambulance department here."

25. After a few minutes, the nurse attached a defibrillator to the man's chest. The defibrillator did not instruct her to shock his heart and so both she and one of the officers continued to administer manual CPR. The nurse recalled, when interviewed, that this continued for approximately 20 minutes and at no point did the defibrillator instruct her to shock the man's heart. Reflecting on what had happened, the nurse told my investigator that she began to lose faith in the machine as she had never used one on her own before. The officer also recalled the confusion they experienced in using the defibrillator. He said:

> "I started giving him mouth to mouth and basically that went on for 25 minutes but there was no like, well there was nothing, there was no air going into him basically, well nothing was actually going into him, you know. Well the nurse tried the defibrillator, she attached the defibrillator to him and that's a machine, I don't know whether you know these machines but it talks, it tells you what to do basically … and it was like telling us to do CPR, which we were doing and then it was telling us to stand back because we were going to shock then, but it never shocked him. We were a bit concerned at the time that we

were doing something wrong … the machine wasn't working and like I say, it kept saying carry on the CPR."

26. The SO took control of the scene and deployed an officer to maintain the wing whilst the nurse and another officer continued with CPR. The SO explained to my investigator that, as the permanent night orderly officer, he is effectively in charge of the prison until such time that he has to notify the governing Governor of a major incident or emergency. Part of that responsibility was to ensure that the wings were still maintained whilst he prepared for the arrival of the emergency services. The SO said that, from his experience of attending incidents, there is a certain amount of "cooling down" required. He recalled that prisoners on A wing would have been able to hear his staff responding to the man's collapse and so he asked the wing officer to quietly communicate with prisoners and to check the one vulnerable prisoner on the wing who was at risk of self harm. The officer carried out his duty and reported no problems.

27. The SO proceeded to prepare the prison for the arrival of the ambulance and paramedics. He told my investigator that this meant he had to unlock all the gates and other access points around the prison in order for the ambulance to drive straight through to A wing. This is the furthest wing from the gate, and as Garth was locked up for the night and a skeleton staff were on duty that evening, he unlocked each gate as quickly as possible and then returned to the man's cell. On arrival, he saw that the nurse and officer were still administering CPR. He told my investigator:

> "At that time I asked the staff. I asked [them], who were clearly getting extremely tired, did they want a relief? Did they want changing over with staff but they were adamant no, they wanted to try and maintain what they were doing, which is quite a thing."

28. The paramedics arrived at approximately 2.25am, and applied their own defibrillator. The paramedic checked the defibrillator the nurse had been using to see if it was in full working order and confirmed that it was. She said that she felt reassured by the paramedic's confirmation that she had used the equipment correctly. The officer recalled the paramedic's explanation of why the defibrillator did not administer a shock. He told my investigator:

> "… then we asked about the actual machine, why the machine actually wouldn't shock him like you know and he [the paramedic] said because the machine itself is excellent for [picking up] vital signs in the body and because it wasn't actually picking any signs up it wouldn't actually shock him. So it was actually set to do that basically."

29. The man was pronounced dead by the paramedic at 2.27am. The wing officer sealed the cell in order to preserve the contents for the police. The SO contacted the duty governor, who immediately made his way to Garth to begin contingency plans for a death in custody.

Events following the man's death

30. The duty governor instructed his staff in Communications to contact all the relevant services listed in the event of a death in custody and phoned the governing governor himself. The police arrived at the man's cell at approximately 4.00am and took statements from the response team. The duty coroner and funeral directors followed shortly after. The Prison Service Order which provides individual prisons with guidelines following a death in custody was closely followed, and the duty governor was able to carry out his command suite duties without any problems.

31. Both the officer and nurse remained on A wing immediately after they were relieved by the paramedics and were initially supported by the duty governor. The nurse then returned to the healthcare unit to catch up with the duties she would have carried out on a normal night shift. She told my investigator:

> "I didn't know the patient, I didn't know his condition and didn't know his name. When I got back to the healthcare, I got his notes out and it all became clear. Everything that's stated in his notes, he wasn't taking his medication or anything. I don't know if it's right to say this but he was a time-bomb waiting to go off. But at the time I didn't know that but even if I did I would have still tried you know, I would have continued with basic life support even if I had known that. His blood pressure was always very high, that's what is stated in his notes."

32. At approximately 4.30am, the governing governor arrived at Garth and notified staff that a de-brief would take place in her office at 7.30am. All staff who responded to the man's collapse provided her with a written statement and a verbal account of their individual roles in responding to the emergency. At the de-brief, the governing governor took the opportunity to thank all her staff for their efforts in attempting to save the man's life.

33. Each member of staff interviewed was asked to comment on the support offered to them immediately following his death. Staff told my investigator that they felt well supported by Garth's senior management and also by each other. All officers and the nurse were given the opportunity to go home, but they elected to stay and complete their shifts. The nurse said that, as a member of the care team herself, she was very aware of the support available after incidents of this nature, and returned to work the following day to find an immediate change in staffing within the healthcare unit. The nurse explained that, as a result of the man's death, the healthcare manager allocated another member of staff to night duty the following night and had also changed shift start times as part of healthcare contingency plans.

34. The nurse explained that, following the man's death, a permanent change to nursing shifts had been secured which incorporated staggered start times. She said:

> "So we now have something else in place. We have something like an early start … we'll have an early start at seven, and officially the rest of

> us start at quarter to eight. Well if something like this happens now in the future, because of the traumatic experience and I was worried about my notes for the patients downstairs … what we have to do now in future is, the person that's on the early start the next morning we immediately phone them. So they would come in and take over that job of maybe coming back to healthcare, they sit and take over the notes, ask the officers what the patients have been like downstairs so they would be able to write in their notes and I would still be on the wings giving evidence and answering questions."

35. When the wing officer approached the end of his shift on the morning of 21 September, he gathered the A wing prisoners together to inform them personally of the man's death. The officer told my investigator that he received a thank you letter from the prisoners he spoke to later that week. The governing governor liaised with the man's next of kin over the next few days and arrangements to cover the cost of his funeral and to send a representative from Garth were put in place.

36. On 25 September, the governing governor issued a notice to prisoners and staff to inform them of the findings of his post mortem. The notice explained that he died suddenly and there was nothing staff could have done to change the outcome. My investigator received a letter for one prisoner on A wing who wrote on behalf of other prisoners to express their thanks to the governing governor and her staff for the way the man's death had been handled.

37. The chaplaincy team at Garth arranged for a service to mark his death and all prisoners were invited to attend if they wished. His funeral took place on 18 October 2006 and was attended by his family.

ISSUES

38. The man's death was sudden. His history of heart problems, high blood pressure and reluctance to take his medication was described by the nurse as a time bomb waiting to go off.

39. His death was a shock to both staff and prisoners and any death in custody can have a profound effect on prison life. Yet it is clear from staff and prisoner responses that everything that could be done was done in response to his collapse and immediately following his death.

40. The man died in the early hours of the morning when the prison was quiet and reduced to a skeleton staff. This made the response to his emergency all the more challenging. The small number of available staff presented the night orderly officer with the specific challenge of deploying his interventions officers to the emergency, whilst he ensured that ambulance access was made as easy as possible. The SO also had to ensure that all prisoners in the immediate area were checked and attended to if required, and that the rest of the prison was kept secure. The SO carried out his orderly officer duties seamlessly. I do not underestimate the difficulties he faced in juggling the priorities of maintaining a safe and secure prison environment whilst at the same time taking overall control of the emergency response.

41. The efficiency with which the SO carried out his duties was also made possible because of the commitment and competence of the staff he relied upon. It is clear from the log maintained by one of the officers, and from the interviews my investigator conducted with staff, that the nurse and the other officer administered CPR for approximately 20 minutes without a break. Both members of staff did not stop immediate life support first aid until the paramedics arrived at 2.25am, and they declined the offer by the SO for other members of staff to step in and relieve them. The application of CPR is physically exhausting and emotionally draining. The length of time both members of staff carried on with the procedure showed great determination and commitment in a stressful and tiring situation.

42. Immediately following the man's death, Garth's local contingency plans for a death in custody were put to the test. They were followed meticulously by the duty governor and the communications staff at the gate. Again, it is clear from the records maintained that the plans were effectively implemented and the governor experienced no problems in following the relevant Prison Service Order.

43. My investigator found that both staff and prisoners at Garth were offered ample support and were provided with relevant information about the man immediately and in the days following his death. The wing officer spoke to prisoners sensitively the following morning, and the governing governor issued a notice formally to announce his death and to thank everyone for their efforts. In addition, my investigator received a letter from a prisoner in response to the notice displayed on A wing. This spoke of the compassionate way senior management and staff handled his death.

44. It gives me pleasure to commend the governing governor, her senior management, staff and prisoners, for the way in which the man's death was responded to from the moment he collapsed to the day of his funeral. Garth should also be commended for the high standard of record keeping throughout his sentence. The content, order and presentation of his records to my investigator made the initial analysis and identification of significant events a straightforward task.

45. That said, and although there would have been no effect on the ultimate outcome for the man, my investigation has highlighted a number of areas where practice could be improved.

Clinical Review

46. Chorley and South Ribble PCT carried out a clinical review of the man's healthcare. In summary, the review confirmed his long standing heart problems and his reluctance to take medication to alleviate his condition. At the time of writing, the clinical reviewer did not have sight of his post mortem results and did not know the actual cause of his death. The review provided the following overview:

> The man was 49 years old with high blood pressure, and had suffered a major illness in June 2003 with a leaking dissecting aortic aneurysm. He was aware of the importance of maintaining a low blood pressure to prevent a recurrence of this problem but he was unwilling to take the medication required, despite the best efforts of the healthcare staff attending to him.

47. The clinical review highlighted three issues of concern following a review of the healthcare records:

i) In June 1996 whilst the man was at HMP Blundeston, regular BP recordings were taken which clearly demonstrated hypertension. There is no record of this being treated and there is then a two year gap in entries until February 1998. This suggests either missing records or a failure of the healthcare staff at the time to follow up this patient's hypertension with appropriate treatment.

ii) During his first 18 months at HMP Garth, he was treated with migraleve but also received 28 prescriptions of paracetamol, 8/16 tablets each time. There is no record of a repeat BP recording during this time.

iii) Letters from Chorley Hospital suggest a degree of confusion as to who was responsible for the follow-up and repeat CT scan for this patient. In March 2004, the cardiothoracic registrar states, "he will need a further CT scan a year from his previous CT scan to compare the two". In October 2004, a final discharge letter from the physician states, "[The] team plan to repeat his CT scan early next year. I will leave his further management in [the registrar's] hands and, as he is quite stable, I have

discharged him from this clinic back to your care." There is no record of any further out-patient appointments and no record that the recommended repeat CT scan was carried out in early 2005 as intended.

48. The clinical reviewer made the following recommendations, which I endorse:

At each reception health screening, healthcare staff should review the full medical record of the prisoner and note any abnormal results which may require further investigation or periodic review.

A policy should be developed to ensure further examination or investigations are undertaken for prisoners who require repeated doses of pain killers, especially for headache.

Prison Healthcare should note the content and recommendations of all hospital letters to ensure that follow up appointments or investigations take place as intended.

Procedure for entering a cell at night

49. In the event of a cell bell being pressed at night, an officer is tasked with making a quick and difficult decision over whether to enter a cell alone. The officer has to ascertain whether a situation is an emergency and potentially life threatening. This is not an easy judgement to make. PSO 2710 Follow up to Deaths in Custody provides guidance on the issue and says:

> "2.3 If the apparent death has taken place in a cell, the first person on scene must enter the cell as soon as possible, following the local strategy for safely doing so. Local protocols must contain clear instructions covering cell entry, especially for Night Patrols. If the death has taken place elsewhere in the prison, follow the local strategy for clearing the area of other prisoners. Carry out emergency first aid procedures described in Annex C of PSO 2700 "Suicide and Self-Harm Prevention" until clinical staff arrive. Prompt assistance - even a few minutes - may save a prisoner's life."

50. Prisons aim to strike a balance between the issues of safety and the preservation of life through local security and safer custody instructions. These instructions help individual officers decide the appropriateness of entering a cell alone. The Prison Service National Security Framework states the following:

> "All prisoners should be locked up unless authorised by management or on the instructions of the Medical Officer. The Night Operating Procedures should state how many staff should normally be present before prisoner accommodation can be unlocked."

The Prison Service has moved away from determining procedures nationally and has introduced locally determined instructions for entering a cell. This

shift in responsibility has been implemented to enable individual prisons to tailor emergency responses more effectively.

51. Garth's night operating procedures for entering a cell in an emergency (Local Instruction 2.76) require officers to refer to the night bag which contains information on action to take in the event of an apparent death in custody. The remainder of the document is written from a security perspective with non-medical emergencies in mind, and makes specific reference to a three man team being present before a cell is opened.

52. Safer Custody guidelines do make specific reference to these situations. Although written with self-inflicted emergencies in mind, they can also be applied to emergency medical situations of a nature similar to the man's and permit officers to enter a cell on their own.

Garth's Death in Custody Protocol sets out initial action to take. Under the heading, Immediate Action on Discovery of Apparent Death, the protocol says:

> "Enter cell as soon as possible. Staff can do so alone, taking into account any risk factors that may exist for their own personal safety, and the safety of the establishment by doing so. If the cell is entered as soon as the discovery is made, staff may be able to make immediate action to help save a prisoner's life."

53. The wing officer was the first officer to respond to the man's cell bell and he did so immediately. The officer was on his own, locked onto A wing for the night, and was carrying a radio and sealed pouch containing one cell key only. He did not enter the cell and elected to raise the alarm by making his way to the wing office where he phoned for assistance. Assistance arrived within three to five minutes. The wing officer told my investigator that he would not enter a cell on his own. The safety of the establishment is clearly compromised when a cell door has to be opened at night, but it is less clear whether the officer weighed up the risk factors to his own personal safety as the local guidance states. However, I do not intend any criticism at the decision of the officer not to enter the cell alone – it was unclear what the situation was and I think many officers would have also elected to raise the alarm and await assistance before unlocking the cell in this situation.

54. In any case, even if the officer had entered the cell immediately and on his own, his actions would not have saved the man.

Housekeeping point

55. I do not underestimate the responsibility an individual officer has in deciding whether, as in this man's case, a collapse is life threatening and whether it is then safe to enter alone. It might be more effective for Night Operating Procedures for night managers and staff to include a short summary of what to do in the event of a medical emergency, and apparent death in custody, rather than to refer officers to another set of procedures filed and stored

elsewhere. Encompassing procedures for all potential emergencies, whether they appear security threatening or life threatening, into one set of instructions might clarify further what immediate action a night duty officer should consider taking. I draw my suggestions to the attention of the governing governor, but make no formal recommendation.

Good practice

56. The onus is on emergency response staff to maintain resuscitation until other medical practitioners arrive at a cell. For the nurse and one of the interventions officers to give CPR to the man for approximately 20 minutes, must have been a traumatic and exhausting experience. I am aware that both have already been commended for their administration of immediate life support first aid. I also commend them for their commitment and professionalism in carrying out such demanding duties.

57. The healthcare centre at Garth had the foresight to prepare emergency equipment in bags for the most common medical emergencies. Having access to a tailor-made bag for a collapse ensured that the nurse did not have to leave the man's cell at any time to obtain vital equipment. This practice saved on time and ensured that the nurse was well equipped to respond to his medical needs efficiently and effectively.

58. Immediately following his death, the Healthcare Manager revised healthcare contingency plans to include an additional member of staff on night duty and to stagger shift start times. This served a dual purpose. First, the nurse was able to return to work that night safe in the knowledge that she had been recognised for her actions, would not be working alone, and was supported by her management team. Secondly, in future where a medical emergency on a wing occupies a nurse's time, another member of staff in healthcare is available to carry out routine duties. The review of procedure has strengthened the healthcare centre's ability to maintain inpatient care through the night, whilst coping with an emergency. The Healthcare Manager should be commended for solving so speedily a continuity of care problem highlighted by his death.

59. Staff and prisoner support following the man's death was plentiful and offered without delay. All staff interviewed said they were very content with the care and welfare services provided. Prisoners on A wing expressed their own appreciation in writing for the way the aftermath of his death was handled. I am grateful for their views and congratulate the governing governor, her senior management team and staff for the compassion and sensitivity they displayed. I would be grateful if she could share that view with all her colleagues.

RECOMMENDATIONS

1. At each reception health screening, healthcare staff should review the full medical record of the prisoner and note any abnormal results which may require further investigation or periodic review.

   The Prison Service accepted the recommendation and said the following:

   "At the time of the man's reception to Garth, no policy was in place to facilitate this. The system was changed in mid 2002 and all prisoners with on-going or newly identified needs are followed up via nurse led primary care clinics".

2. A policy should be developed to ensure further examination or investigations are undertaken for prisoners who require repeated doses of pain killers, especially for headache.

   The Prison Service accepted the recommendation and said the following:

   Pharmacy/medication policies have already been reviewed. Nursing staff are limited to the amount of 'over the counter' (e.g Paracetamol) medications they can give, once a prisoner requests in excess of this amount they are referred to the GP".

3. Prison Healthcare should note the content and recommendations of all hospital letters to ensure that follow up appointments or investigations take place as intended.

   The Prison Service partially accepted this recommendation and said the following:

   The noting of the contents and recommendations of hospital letter is established practice. Responsibility for ensuring attendance at follow up appointments is accepted as the responsibility of Prison Health Care as is the undertaking of any recommendations that can be implemented or delivered in the establishment. However, the responsibility of ensuring that further instructions and investigations, ordered by the consultant, are undertaken lies with a consultant.