Investigation into the circumstances surrounding the death of a prisoner at HMP Wakefield on 2 October 2008

Report by the Prisons and Probation Ombudsman for England and Wales

July 2009

This is the report of an investigation into the death of a prisoner at HMP Wakefield. A prison doctor had examined him on the afternoon of 2 October 2008 after he complained of a sore throat. He was diagnosed with tonsillitis and prescribed antibiotics. However, after returning to his wing, his condition deteriorated and he was seen during the early evening by medical staff following a number of emergency calls. At 6.30pm that evening, the man collapsed in his cell and staff immediately called again for medical assistance. Sadly, he never regained consciousness and was confirmed dead by paramedics just after 7.00pm. He was 39 years old. A subsequent post mortem established that the cause of death was acute inflammation of the larynx and epiglottis. I understand that this is a rare condition, and one that is difficult to diagnose. It can have fatal consequences very quickly.

I know that the man's death came as a great shock to his family and friends, and I add my condolences to those already expressed by my investigator and family liaison officer.

One of my investigators conducted the investigation on my behalf. I would like to thank the Governor of Wakefield, and her staff for their co-operation and assistance. Particular thanks go to the prisons liaison officer who made all the practical arrangements for my investigator.

Wakefield Primary Care Trust (PCT) arranged a review of the man's medical care in custody. I am grateful to the review team for their timely and thorough report. I am also grateful to Wakefield PCT for commissioning a report from an Ear, Nose and Throat (ENT) specialist following the publication of the post mortem findings. A separate specialist review commissioned by West Yorkshire Police comes to different conclusions and calls into question the actions of the doctor who first examined him.

I draw attention to the prison's good practice in being clear and open at the outset regarding the financial contribution they would make towards the funeral, and commend the actions of one member of staff. I make one recommendation relating to equipment being carried to medical emergencies, and I endorse a further three made by the clinical review team in respect of staff training and the management of medical emergencies.

Stephen Shaw CBE
Prisons and Probation Ombudsman **July 2009**

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SUMMARY

The man was remanded into custody at HMP Pentonville in November 2000. While at court, staff placed him on suicide and self-harm monitoring (F2052SH). He was monitored for most of his time on remand due to his depression and anxiety. In addition, medical staff assessed his hiatus hernia on a regular basis.

In January 2001, he moved to HMP Belmarsh for the currency of his trial and staff continued to monitor him. After he was sentenced to life imprisonment in September 2001, he remained in the care of the mental health team in relation to his ongoing psychological problems, but often failed to attend for appointments. He remained at Belmarsh for almost a year during which time his medical problems appeared to settle.

The man transferred to HMP Wakefield in August 2002. A doctor at reception conducted a full assessment of his previous medical history. Thereafter, apart from collecting daily medication, his contact with healthcare was sporadic and he would often fail to attend appointments. He settled quickly into the residential unit and established a close circle of friends. Staff also described him as a polite individual who seldom gave cause for concern. As part of his sentence plan, the man was encouraged to undergo the Sex Offender Treatment Programme (SOTP) which he was close to completing at the time of his death.

On 2 October 2008, he attended his offending behaviour group during the morning, where it was reported that he worked well. On his return to the wing, he told his close friend, that a sore throat was developing. At 2.00pm, prisoners were unlocked to attend their afternoon activities. However, the man's throat felt worse and he was seen by a Senior Officer. She was concerned that the man was having difficulty breathing, and another officer present requested medical assistance via her radio. Nursing staff went to the wing to assess the man before taking him to the medical centre to be examined by the prison doctor.

During the consultation with the doctor, the man was reportedly very agitated. The doctor diagnosed tonsillitis and prescribed a course of antibiotics. However, the man was not convinced that this was the cause of the pain in his throat and, before returning to the wing, asked to see the doctor again. On this occasion, the doctor carried out a more extensive examination to rule out any other possible cause. This appeared to reassure him.

Shortly after his return to the wing, the man pressed his cell bell and banged his door. Officers on the wing went to the cell and, on seeing him in some distress, requested medical response via the radio.

A healthcare officer, who had brought the man back from the healthcare centre and was aware of the earlier diagnosis, went to see him. The healthcare officer explained that the man was having a panic attack and that he needed to control his breathing and allow the medication time to work. He also told him that he would check on him again later that evening.

Over the next 90 minutes, wing staff made a further three emergency calls to obtain medical assistance for him. On each occasion, another healthcare officer attended in his role as Hotel 5 (first response) and advised the man to try to control his breathing. During the penultimate call, staff asked the healthcare officer whether he thought it appropriate for the man to be moved to the healthcare centre for observations, which he said he would arrange. However, while the move was being dealt with, he collapsed and an officer made a final call for medical assistance.

Nursing staff went to the cell and attempted to resuscitate him until the arrival of paramedics who then continued the treatment. Despite their best efforts, the man failed to respond and he was pronounced dead by paramedics at 7.04pm.

Although initial speculation was that he had suffered an allergic reaction, the results of a post mortem and toxicology gave the cause of death as respiratory obstruction, consequent upon severe laryngeal inflammation, which had progressed to abscess formation. Wakefield PCT and West Yorkshire Police both commissioned reports from Ear Nose and Throat specialists regarding the man's death. The two reports come to different conclusions, and that commissioned by the police calls into question the actions of the prison doctor.

I make three recommendations relating to healthcare and one in relation to management of incidents. I also commend the positive actions of the first healthcare officer in his initial dealings with the man, as well as the helpful family liaison offered by the prison.

THE INVESTIGATION PROCESS

1. One of my investigators was appointed to conduct the investigation on my behalf. HMP Wakefield issued notices to staff and prisoners informing them of the investigation process and inviting anyone who had relevant information to come forward. In response to the notices, my investigator received letters from seven prisoners at Wakefield asking to speak with him.

2. Wakefield Primary Care Trust (PCT) carried out an independent review into the man's medical care while in custody. A copy of their report is attached in full as an annex.

3. My investigator initially visited Wakefield on 20 November 2008 to interview three prisoners who had contacted him. On 6 January 2009, he returned to Wakefield and over the course of two days he interviewed a further four prisoners and six staff. Three of the staff were members of the healthcare team and were interviewed jointly with members of the clinical review team. The investigator spoke to another two members of staff by telephone.

4. The prison contacted West Yorkshire Police following the man's death and a detective constable carried out interviews with both staff and prisoners. My investigator contacted the detective constable who confirmed that the police had no concerns about the circumstances of the man's death. Copies of all police interviews were shared with my investigator.

5. The Head of Healthcare at Wakefield was appointed as the prison's Family Liaison Officer. He contacted my office on 27 October to pass on details of the man's next of kin.

6. One of my own Family Liaison Officers telephoned the man's sister on 7 and 10 November to explain the role of my office and the purpose of the investigation. His sister told my family liaison officer that the family's biggest concern was how such a young man had come to die so suddenly. My family liaison officer followed up her telephone calls with a letter to the family and provided further information. I hope that my report helps them to understand the events leading up to the man's death.

HMP WAKEFIELD

7. HMP Wakefield is a prison for those serving four years or over, including life sentenced prisoners. It is part of the high security estate.

8. The prison provides workshops and an education department offering both full and part time education. The programmes department offers a range of offending behaviour courses including FOCUS (drug programme), Sex Offender Treatment Programme (SOTP) and the Enhanced Thinking Skills (ETS) programme.

9. The prison's healthcare centre is separate from the main residential areas. All the cells have integral sanitation and the prison has recently been refurbished.

10. The most recent report on Wakefield by HM Chief Inspector of Prisons, Dame Anne Owers, was issued in April 2005. (It was a follow-up to an announced inspection 18 months earlier.) In her report Dame Anne concluded that:

> "Overall, Wakefield was clearly a prison on the move. But there was a great deal of movement still required in order to make it a fully effective prison, able to engage properly with the serious and difficult offenders that it holds."

In relation to the healthcare at Wakefield, Dame Anne reported:

> "There had been little change in healthcare facilities since the last report. Wakefield provided 24-hour care for prisoners and had a 20-bed inpatient facility. Staff were enthusiastic and committed to improving services but there appeared to be a lack of strong clinical leadership, particularly in the primary care area."

11. The Independent Monitoring Board (IMB) at Wakefield published their most recent annual report in April 2008. In their report they said of healthcare provision which had undergone a number of changes:

> "The commissioning process of services by the PCT is now providing an increase in resource and investment, this along with the appointment of a new Head of Function and a new healthcare manager, both of whom have embarked upon a pro-active management style, has resulted in the provision of better services and an increase in moral amongst staff"

12. My office was given responsibility for conducting investigations into all deaths in prison custody in 2004. Since then there have been seven deaths attributed to natural causes at Wakefield.

KEY FINDINGS

Initial time in custody

13. The man was 31 years old when he was remanded into the custody of HMP Pentonville on 11 November 2000. He had been in custody on previous occasions and had been released from Pentonville in October of the previous year.

14. While at court, staff had become concerned about him as he appeared very distressed. As a result, they opened a Self-harm at Risk Form (F2052SH). (This form has since been replaced by the Assessment, Care in Custody and Teamwork (ACCT) process.) The purpose of the document was to identify and provide extra support and observation to help prisoners at risk of suicide or self-harm. The form opened at court was passed to prison staff when he was taken into custody at Pentonville.

15. As part of the reception process, a nurse spoke with the man and completed an initial health screen. The nurse recorded that healthcare staff knew him as he had spent the majority of his recent sentence located in Pentonville's healthcare wing. He told the nurse that he was very depressed and had been since the death of his wife. The nurse also recorded that the man was receiving medication for depression, and was awaiting the results of tests for possible bowel cancer. The nurse arranged for him to be located in the healthcare wing.

16. Despite being familiar with the prison regime, he remained very depressed during his time on remand. He was seen regularly by a doctor and case reviews of his F2052SH determined that the monitoring should continue.

17. The man had suffered from a hiatus hernia (when part of the stomach pushes through the diaphragm into the chest causing symptoms such as heartburn, nausea and regurgitation) during an earlier period of custody. While on remand, he was referred again for an endoscopy (when a camera is inserted into the body via the throat) in relation to the same condition. During an assessment by a member of the healthcare team, he also stated that he had been diagnosed with cancer of the colon in 1999 and treated with chemotherapy. The prison healthcare department contacted the hospital where he said that he had been treated but no records could be found.

18. On 23 January 2001, the man was transferred to HMP Belmarsh in order to attend his trial. On reception, he told staff he believed that he should not have been transferred before he had his endoscopy. Medical staff made a note of his outstanding appointment which was followed up without delay. During his time at Belmarsh, he was assessed on a regular basis by both healthcare staff and the mental health team as he continued to experience anxiety and depression. This resulted in him being placed on F2052SH monitoring on a number of occasions.

19. He committed minor acts of self-harm but the most significant was when he attempted to hang himself in April 2001. Fortunately, staff intervened in time and the ligature was removed in time to save his life. During an assessment by the mental health team following his attempt to take his life, he said that he had wanted to kill himself at the time but no longer felt suicidal. He said that the attempt was due to him having a personality disorder and suffering from manic depression.

20. In September 2001, he was convicted and sentenced to life imprisonment. He continued to be seen by the mental health team. It is recorded in his medical notes that there were a number of occasions when he failed to attend these appointments. It is also noted that his gastric problems continued but he managed this himself, opting to eat a bland diet chosen from the menu and supplementing it with Weetabix.

Transfer to HMP Wakefield

21. On 29 August 2002, the man transferred to HMP Wakefield. He arrived on 30 August after an overnight stay at HMP Woodhill. On reception, a doctor carried out a thorough assessment of his previous and existing medical history. The doctor made the following entry in the man's medical record:

> "On Going Diagnoses – multiple ulcers – bland diet for last 13 months, complaining of dysphagia [difficulty in swallowing]. Asthma – Salbutamol"
>
> "History of manic depression, personality disorder. Last depressed 12 months ago."

22. The doctor also recorded the man's family history and concluded that he was fit, well, and suitable for normal location within the prison. During the remainder of 2002, he reported sick regularly and complained of feeling unwell or being depressed. He also said on several occasions that he was not eating. Because of these symptoms, nursing staff kept a check on his weight and carried out various tests to identify a possible cause. However, despite him initiating the contacts with healthcare, he would often fail to attend follow up appointments.

23. In January 2003, the man attended an appointment with the Senior Medical Officer (SMO). He recorded that the man did not appear to know why he was seeing him and equally he knew nothing of his medical history. Despite this, the SMO continued with the appointment discussing with him his previous stomach problems. The man raised the matter of his diet but the SMO did not pursue this with him. He asked him about his reasons for refusing to attend previous appointments. At this point, he recorded that the man became verbally abusive towards him and the appointment was terminated. He wrote on the medical record that he would refer the man for a repeat endoscopy.

24. On 9 January, staff on C wing asked a doctor to see the man as he had run out of the medication he was taking for depression and they were concerned that

he was not coping without it. The doctor conducted a thorough examination, during which he again recorded the man's previous and current medical history. He concluded that the man was coping poorly, misusing his prescribed medication and was at risk of self-harm. In order to help him, the doctor planned the following action:

- "Open 2052SH
- Excuse Labour
- Check with SMO: Medication
- Refer Psychiatrist, RMN
- Review sick parade Monday"

25. A psychiatrist assessed the man on 14 January. He completed an in-depth interview with him, recording that he had previously responded to medication. The psychiatrist prescribed the man's previous dose of anti-depressants. He then reviewed him weekly until December 2003. The man's medical record shows that between these appointments, he did not always attend to collect his medication but it was kept under review throughout his time at Wakefield.

26. Between 2003 and October 2008, the man had limited contact with healthcare for reasons other than for medication. In April 2004, he received treatment for minor injuries after fighting with another prisoner, and in February 2005 he was sent to outside hospital for treatment on a wound to his mouth. He initially told the nurse that he thought he had suffered an epileptic seizure, but later said that he had been attacked. He was taken to the local hospital as a precaution, but returned to the prison the same day.

Events of 2 October 2008

27. On 2 October 2008, the man was unlocked as usual at 8.00am. His close friend and fellow prisoner of the man made a statement to the police and was also interviewed by my investigator. He said that he went to the man's cell in order to have a cup of coffee before the man went to his morning group session. He was located about halfway along on the fours landing which is two flights of stairs up from the ground floor. They sat drinking coffee and watching the news until around 8.25am when the man left for his course. His close friend said that during this time the man seemed in good spirits, and did not complain about feeling ill.

28. The man remained at his group all morning, returning to C wing at around 11.30am. On his return, he went to his cell and made coffee for himself and his close friend whose cell was two doors along on the same landing. The man's friend told my investigator that he returned with him to his cell to have the coffee, and asked how his morning had gone. The man told him that he had a sore throat coming, and kept touching his neck. At 11.45am, the man said he was going to the prison shop to see if he could get something for his throat. He bought some menthol sweets and vapour rub, which he rubbed on his throat. At 12.30pm, his friend returned to his own cell. He had no concerns at that time, as the man was not complaining too much about his throat.

29. All the prisoners are locked in their cells over the lunch period and unlocked at 2.00pm to attend afternoon employment. His close friend said he went to the man's cell shortly after being unlocked. The man told him that his throat was getting worse and asked him to get a member of staff to come and see him. His friend said that he went downstairs intending to go to the wing office, but met a female officer on the second floor landing. He told her about the man, and asked if a member of staff could go and see him. His friend then returned to the man's cell and told him that someone was coming. At this point, he returned to his cell. He said that he did not see the man again that afternoon, but he heard a tannoy call shortly after returning to his cell instructing the man to report to the senior officer on the second landing.

First emergency call and examination by the prison doctor

30. Following the tannoy call, the man reported to officers as instructed. In interview, the wing Senior Officer (SO) said that she saw him standing by the gate that led off the wing, and he appeared to be having trouble breathing. The SO told the man to sit down on a chair, and an officer who was also present called for code blue medical assistance, via her radio. (Wakefield uses two coding systems for medical emergencies, red and blue. Blue indicates that a person has breathing problems and red that the person is bleeding. The codes allow medical staff to respond with appropriate equipment.) The officer's call was recorded in the control room at 2.16pm. (The control room is the prison's communication centre, operating the internal and external telephone system. In addition, the two-way personal radio system is controlled by the base station located in the control room. Call signs for staff are allocated by the control room staff and all emergency calls are managed by control room staff.)

31. In response to the code blue call, two nurses went to C wing. One of the nurses said that she knew the man well and had spoken to him earlier that morning regarding the distribution of health information leaflets. She said that, at that time, he had seemed in good health and had not mentioned feeling ill. On arrival at the SO's office, wing staff informed the nurses that the man had previously been short of breath. The man told them that he had a sore throat and had had a coughing fit earlier. On examination, the nurse said that the man was talking in full sentences, and his breathing appeared normal. However, as a precautionary measure, the nurses accompanied him to the treatment room to examine him properly. One of the nurses examined his throat with an auroscope (medical instrument consisting of a magnifying lens and light) and could see that his throat was inflamed. The nurses decided to take him across to the healthcare centre to be seen by a locum doctor who is commissioned by Wakefield PCT to provide a GP service.

32. In a statement made after the man's death, and during interview with my investigator, the doctor said that she was made aware that the man had been brought to healthcare as an emergency, and she checked his medical history before he arrived. The doctor noted that he had previously been treated for asthma in 1983, but was not currently receiving medication. In addition, she noted that more recently he had a history of anxiety and depression.

33. The doctor said that, when the man came into the consulting room, her observation of his appearance was not of breathlessness or of a severely ill patient. With the information already provided by the nurses, she had several possible diagnoses in mind before he arrived. These were:

    - Asthma, given his past medical history.
    - Anaphylaxis (allergic reaction), although there was no known allergy documented on his medical notes.
    - Foreign body inhalation.
    - Acute epiglottitis. (A condition in which there is inflammation of the epiglottis and commonly the soft tissues surrounding the epiglottis. The condition is rare, but can be life threatening as inflammation of the epiglottis and surrounding tissues may lead to the complete obstruction of the upper respiratory tract.)
    - Anxiety, from which he suffered in 2003.

34. However, the doctor said that her initial observation was that the man was breathing normally, at a rate of 18-22 breaths per minute, and not using any accessory muscles. (Accessory muscles are only used during forced breathing e.g. during heavy exercise, or asthma attacks.) She added that his colour was normal, and he did not have laboured (difficulty) breathing or any sweating. The doctor asked him to explain how his symptoms had started. He said that his throat had become sore at around 9.00am that morning, and that had become progressively worse. He felt a burning sensation in one side of his throat, and swallowing had become harder. The doctor told my investigator that she asked the man whether he had any rash or itchiness, to which he replied in the negative.

35. While asking these questions, the doctor said that she observed him and he was speaking normally. There was no indication of asthma or anaphylaxis but she was aware that she needed to rule out acute epiglottitis.

36. To enable the doctor to rule the possibility of acute epiglottitis, she went closer to him. She told my investigator that she noticed that his was breathing without any extra stridor sounds (an abnormal, high-pitched, musical breathing sound caused by a blockage in the throat or voice box) or wheezing. The doctor asked him to open his mouth, which he was able to do and this indicated there was no ‘trismus’ (inability to open the mouth fully). There was no excessive saliva. If present, these symptoms would have indicated the possibility of acute epiglottitis, and she said she would have sent the man straight to outside hospital.

37. The doctor explained to my investigator that, after ruling out other causes, she diagnosed him as having acute tonsillitis as his throat was severely inflamed and he had trouble swallowing. She also said that he had appeared agitated during her consultation, but she thought this was due to his history of anxiety and that he felt unwell. The doctor prescribed antibiotics to treat his throat infection and soluble aspirin to gargle and alleviate the discomfort. At the end of the consultation, the man was placed in a holding cell in the healthcare centre until he could be escorted back to the wing.

38. A healthcare officer (HCO) was on duty in the healthcare centre overseeing the afternoon doctor's surgery. It was his task to collate the appointment lists and complete risk assessments prior to the doctor seeing patients. The HCO told my investigator that he recalled hearing the code blue call on C wing just after lunch, and was aware that the man was being brought over to see the doctor. Following the man's consultation with the doctor, he spoke to him while he was waiting for his medication. The man appeared agitated so he reassured him about the medication that had been prescribed. Both the HCO and the doctor, who was able to hear the man from her office, mentioned that he became very vocal, demanding to be returned to the wing immediately. However, the HCO explained to him that he would need to wait until other prisoners returned from their workshops.

39. The HCO said that at 3.45pm he contacted the Principal Officer (PO), the manager on C wing. He told him that the man had been diagnosed with tonsillitis, and was becoming anxious, and had been prone to panic attacks in the past. While waiting to return to the wing, the man told the HCO that he was unhappy with the doctor's initial diagnosis and asked to see her again. The HCO said that the clinic had finished at this point so it was easy for the man to be seen again. He escorted him to see the doctor for the second examination.

40. At interview, the doctor said that the man returned at 4.00pm with the HCO. He asked her to explain the diagnosis and also asked why the pain was getting worse. The doctor explained the medication and told him that he would begin to improve after about three doses and he should try to take three that day. The doctor said that there were no signs of his condition having deteriorated since the first consultation an hour earlier. However, he remained unhappy so she decided to conduct a full check to ensure that she had not missed anything and to reassure him.

41. The doctor used a pulse oximeter (a device that indirectly measures the oxygen saturation of a patient's blood) which showed that the oxygen saturation of the man's blood was 98 per cent. She also observed that his pulse and blood pressure were normal. During her interview with my investigator, the doctor said that, although she initially thought that the man's pulse was on the high side of normal, she was also aware that he was very agitated and angry which could have accounted for this. After she explained the test results to him, he calmed down. He then took the prescribed medication and was escorted back to C wing by the HCO. The doctor said that she had no further dealings with the man and left the prison at around 5.00pm.

42. The HCO said that the man did not appear to have difficulty talking and walked unassisted back to his cell in C wing. Due to his continued worries about the man's condition, the HCO informed the wing SO of the doctors diagnosis.

43. An officer who was on C wing helping to lock cells after prisoners had returned from work, said that he was standing outside the man's cell when he appoached and went into his cell without speaking. The officer thought this was strange as the man would always make conversation with staff. The

officer continued along the landing to make sure that all prisoners had returned from work.

Second emergency call

44. Shortly after getting back to his cell, the man banged on his door and pressed his cell call bell. The officer, who was still on the landing, told my investigator that he looked through the observation panel into the cell and saw the man pacing around holding his throat. He immediately knew that he had a problem so he attempted to call a code blue via his radio, but found he was not on the radio net. The call was made instead by another officer who had heard the commotion from the third landing and seen the officer at the man's door. The call was recorded in the control room at 4.26pm. The officer at the man's cell knew that the officer who made the call had dealt with him earlier in the afternoon so was aware that he had a medical problem. The officer, along with a second officer, entered the man's cell. He told my investigator that the man appeared to be having difficulty breathing and was quite agitated. The officer reassured the man, and advised him to sit down. He then began to administer first aid, first checking his airways.

45. The emergency call had been heard by a Principal Officer (PO) who was carrying out the role of Oscar 1. (This meant that he was responsible for managing any incidents that occurred in the prison that day.) As the PO reached C wing, he saw the HCO who had been speaking to the wing SO about the man and the diagnosis made by the doctor. The HCO was not carrying a radio, but the PO told him of the call and asked him to accompany him to the man's cell.

46. When the HCO arrived at the cell, the man was standing up and complaining about the soreness in his throat and difficulty breathing. The HCO said that the man showed no signs of cyanosis (blueness in the lips) but was talking in an agitated voice. He advised him to calm down and to try and control his breathing. When asked by my investigator whether he had carried out a physical examination the HCO replied that he did not. The man mentioned his previous panic attacks. The HCO told him that healthcare staff would see him in 30 minutes to see if the medication had begun to take effect, and would keep an eye on him during the evening.

47. As the HCO and PO left the landing, they were met by another HCO. The second HCO was carrying out the role of Hotel 5 which meant that he was responsible for responding to any medical emergencies within the prison. The first HCO told him about the doctor's diagnosis and the medication provided. At interview, the second HCO explained that, although the man had been seen by his colleague, he felt that he should also see him in his capacity as Hotel 5. The second HCO said that he went inside the cell and the man was standing up and breathing rapidly. The second HCO reassured him and told him to sit down on his bed and breathe deeply. He told my investigator that he did not physically examine the man. The second HCO said that the man appeared to relax, and he then advised him that if his symptoms continued he should tell the wing staff.

48. At 4.45pm, prisoners were unlocked to collect their evening meal and for association. (Association is time that prisoners have out of their cells to make telephone calls, talk with friends, or take part in wing activities such as pool.) The man's close friend, said in his statement and during interview that he went to the man's cell shortly after being unlocked. He found him struggling to talk and finding it hard to get his breath. He said that the man told him he had been to see the doctor during the afternoon but his throat was getting worse. He also mentioned that it could be a reaction to nuts.

49. The friend told the investigator that the man had mentioned on a number of occasions that he was allergic to nuts and it was common knowledge amongst his close friends. (The man's sister said in a statement to the police that, as far as she was aware, her brother had never suffered from any form of allergy but was known to suffer from anxiety attacks and had been prescribed an inhaler for this purpose.) Toxicology tests carried out after his death indicated no evidence of any allergic reaction.

50. The friend said that he stayed with and tried to comfort the man, who was panicking about his throat hurting and not being able to breathe. At the man's request, his friend went to get the officer who was on duty on the landing.

51. Around the same time, the another officer had gone to speak with the wing SO to inform her that staff were becoming concerned that the man was getting worse. The SO spoke with a staff nurse at the healthcare centre. (the SO initially asked to speak with the HCO from the afternoon as she was aware that he had dealt the man earlier, but he was not available.) She therefore explained her concerns to the staff nurse who already appeared to know about the man and said that he would pass on the concerns to the HCO. The orderly officer was also in the wing office, and the SO asked him to go with her to the man's cell to check on his welfare and to give some reassurance to staff.

Third emergency call

52. The officer who had been summoned by the man's friend said that he was approached him about ten minutes after prisoners had been unlocked. He said that the man's friend was concerned about him and asked the officer to go to his cell. When the officer got to the cell he saw that the man was still very agitated and so he reiterated the advice the HCO had given earlier. The officer said that another of the man's friends, also came into his cell and the officer decided that he should call another code blue. This call was recorded in the control room at 4.52pm.

53. An SO who was in the contol room that day said in his police statement that he was concerned that the code blue calls had been made to the same wing in such a short space of time. He therefore contacted the orderly officer who informed him that he was aware of the situation on C wing and was monitoring it.

54. When interviewed by my investigator, the second friend of the man said that when he went into the cell, the man was “all over the place”. He put his arms around him and repeatedly told him to calm down. The second friend said that he tried to get the man to sit down but he said that he found it even harder to breathe when he sat down.

55. The orderly officer and wing SO were making their way to the cell when the third code blue was called. The orderly officer said that, when he arrived, the officer the man’s second friend and his close friend were there and other prisoners were outside. He asked the prisoners to clear the area to allow the man space. The man was standing and making gasping noises. The orderly officer said that the second friend was standing behind the man with his arms around him, and he thought that if he was struggling to breathe this probably would not help. The orderly officer said that, at this point, the second friend began shouting at him saying that staff were not looking after the man, that he was being neglected, and that healthcare staff were not treating him correctly. The orderly officer said that he responded by telling the man’s second friend that neither of them were “medics” and the man’s treatment should be left to the medical staff. According to the orderly officer, the second friend then swore at him and walked out of the cell as Hotel 5 arrived.

56. The man’s second friend told my investigator that the orderly officer had sworn at him during the verbal exchange and this allegation was put to him. The two parties give different accounts of what was said, but it is undisputed that a verbal exchange took place regarding concerns for the man’s welfare. My investigator asked all the other people interviewed if they had witnessed any derogatory comments being made by either the second friend or the orderly officer, but no one could corroborate what had been said.

57. When Hotel 5 arrived at the cell, he offered the man reassurance and tried to calm him down to ease his discomfort. My investigator asked whether he took any equipment on this occasion or if he had physically examined the man, and Hotel 5 said that he had not. He explained that he did not examine the man as he was aware that he had been seen by the doctor earlier in the afternoon and diagnosed with tonsilitis.

58. The wing SO recalled the man telling Hotel 5 that he was concerned as his mother had died due to problems with her throat. He also asked Hotel 5 for oxygen but was told that he did not need it. (A police statement provided by the man’s sister indicated that his mother had died as a result of heart failure and diabetes, not a throat ailment.)

59. The man was advised by the wing SO to try to write down anything he wanted to say rather than attempt to speak as this was proving difficult. The wing SO also said that she asked the man’s friend to find a large paper bag for him to breathe into to prevent him from hyperventilating. Hotel 5 and the Orderly Officer left the cell and the wing SO remained with an officer to try to comfort the man. The wing SO then returned to the second landing.

Fourth emergency call

60. A short while later, the landing officer was approached again by the man's friend who asked him to go and see him. The officer explained to my investigator that, as he made his way to the man's cell, he saw him come out onto the landing and fall over, striking his head on the floor. He said that before he fell he was very animated, his arms were flailing and his breathing was loud. On seeing him fall, the officer called another code blue via his radio and, with the help of the man's friend, lifted him back into his cell. The control room recorded this call at 5.31pm. The officer said that he made a visual check of the man and there appeared to be no injuries.

61. The wing SO responded to the code blue call and saw the man sitting on his bed. He had removed his shirt, was visibly sweating and gasping for breath, and making a very loud rasping noise as he breathed. The officer told the wing SO that the man had just fallen and hit his head outside the cell.

62. Hotel 5 arrived and staff told him what had happened. He checked the man for injuries and asked him if he was alright. The man replied that he did not have any injuries or pain. He was still complaining about his throat and Hotel 5 felt that the presence of the man's friend, was unsettling him as he was "acting irate". He therefore told his friend to let him deal with the man. My investigator asked Hotel 5 if he had brought any equipment with him or carried out a physical examinaion when answering this further code blue call. Hotel 5 replied that he had not.

63. In her statement and during interview, the wing SO said that Hotel 5 said that the man could not be that ill if he was still walking around the cell and that he was having a panic attack. The wing SO also said that the man's friend tried to explain to Hotel 5 that the man was not having a panic attack but could not breathe, to which Hotel 5 replied, "Who are you, am I the medic or you?" The wing SO said that this clearly upset the man's friend who was concerned for his friend. When asked about the content of the conversation with the man's friend, Hotel 5 said that he recalled speaking to him but could not remember exactly what was said.

64. Hotel 5 asked the man if he felt that he needed to go across to the healthcare centre and he indicated that he did. He told him that he would arrange for him to be admitted. The wing SO said that Hotel 5 told her that he was going to arrange for a stretcher chair to be brought to the landing so that the man could be transferred. Hotel 5 left the landing and the wing SO remained. She instructed the man's friend to pack a bag for him to take to healthcare. While this was being done, the wing SO and the landing officer continued to try and comfort the man who was still struggling to breathe.

65. While he was being seen by Hotel 5, the orderly officer had also heard the code blue. He said in his statement that he was becoming concerned by the number

of code blue calls as they were unnerving both staff and other prisoners. He spoke to the Duty Governor to explain what had been happening and discussed the possibility of admitting him to the healthcare centre for observations. They agreed that this would be in the man's best interests, despite the earlier opinion of medical staff that his condition did not require it.

66. After leaving the man, Hotel 5 went to the wing office. He told the orderly officer that he had already spoken with the nurse in healthcare and, although they felt it unecessary, they were going to observe him in healthcare overnight. Hotel 5 then went to the treatment room and continued issuing medication to other prisoners.

67. Hotel 5 left to get the stretcher chair and the wing SO remained in the cell for about 20 minutes, waiting for him to return. She said that, during this time, the man continued to struggle with his breathing. She saw the orderly officer on the landing and he asked whether the man was still in his cell. She confirmed that he was and they were waiting for Hotel 5 to return with a stretcher chair. In his statement, the orderly officer said that there appeared to have been a breakdown of communication between Hotel 5 and the SO. He told the wing SO that Hotel 5 had told him that wing staff were arranging the move.

68. The wing SO explained to the orderly officer what Hotel 5 had told her and went down to the treatment room to ask him about the stretcher chair he had intended to collect. Hotel 5 told the wing SO that he was issuing medication and that wing staff would have to walk the man to healthcare. The wing SO responded that the man was too ill and unsteady on his feet to walk, and that she was concerned that he could collapse. Hotel 5 replied that the nurse in healthcare had informed him that wing staff were to take the man. The orderly officer then asked the wing SO to find a wheelchair.

69. As the wing SO was about to go and look for a wheelchair, she was approached by the landing officer who told her that the man was in distress and was now finding it really difficult to breathe. The wing SO asked the officer if she could go back to him and see if he was able to start making his way off the landing.

70. Another officer, who had remained with the man, said that another of the man's friends also came into the cell and attempted to reassure the man. Shortly afterwards, the man collapsed to the floor and the officer and his friend placed him in the recovery position. The officer said that he checked to see if he was breathing and felt that he was. He then called a code blue via his radio. (This was the fifth code blue call and was recorded by the control room at 6.04pm.) In his statement, the officer said that his colleague returned to the cell just as the man had collapsed. She said that Hotel 5 was busy issuing treatments and that she had been asked to take the man downstairs. The officer told the investigator that he could not believe what was happening and told his colleague to get a manager to take control of the situation.

Fifth emergency call

71. The officer went back downstairs and told the wing SO that the man had collapsed and was unconcious. In the meantime, the other officer had called the code blue again as the man had now started to turn blue. The wing SO said that it was around 6.00pm and she immediately made her way to the cell.

72. The Deputy Governor had arrived at the wing along with the security PO. The Deputy Governor told my investigator that he and the PO saw the wing SO and the officer hurriedly making their way to the fourth landing so they followed behind. The Deputy Governor recalled that as they were following, the PO heard the code blue call over her radio, indicating that someone had breathing difficulties on the fourth landing.

73. The wing SO went straight into the cell. She saw him lying motionless on the floor and his face appeared to be purple. The officer, and his two friends were in the cell and the prisoners were asked to leave. The wing SO remained in the cell until the medical staff arrived. A call was received by the control room from the wing SO at 6.10pm requesting an ambulance to attend C wing.

74. When Hotel 5 heard the code blue call over the radio, he asked the control room if the call was for the man. They confirmed that it was and that he had apparently stopped breathing. In his statement, Hotel 5 said that he then picked up the emergency response bag from the treatment room and he and a nurse made their way quickly to the cell.

75. During the investigation, my investigator was told by a number of prisoners that they felt that Hotel 5 made no attempt to respond quickly to the code blue calls, and he was said to have walked along the landing to the last call. When asked about this, Hotel 5 said that it probably took less than a minute to get to the cell. When asked if he had walked or run, Hotel 5 said that he was carrying the response bag containing an oxygen cylinder. He said that he went as quickly and as safely as possible.

Resuscitation attempt

76. Hotel 5 said that as he and the nurse approached the cell there were a number of staff and prisoners around the area. He went inside and was told by the officer that the man's lips had turned blue. This was the first occasion that the nurse had attended to the man during the afternoon. In her statement, the nurse said that she had originally gone to C wing with Hotel 5 when he responded to the code blue at 4.30, but she had no contact with the man as Hotel 5 had dealt with him.

77. Hotel 5 and the nurse said that there was no response from the man and the nurse could feel no pulse in his neck. At this point, the nurse cleared the man's mouth, tilted his head back and began to administer oxygen via a mask. While she was doing this, Hotel 5 began cardio pulmonary resuscitation (CPR) chest compressions.

78. The HCO who had dealt with the man earlier in the afternoon had been working in the healthcare centre, and was informed by the nurse in healthcare that he should go to C wing to assist. The HCO told my investigator that, en route to C wing, he went into the centre treatment room to collect additional equipment including the defibrillator and an oropharyngeal airway. (A defibrillator is a portable electronic device that automatically diagnoses potentially life threatening cardiac arrhythmias and is able to treat them through defibrillation, the application of electrical therapy, allowing the heart to re-establish an effective rhythm. An oropharyngeal airway is a device used to maintain an open airway.)

79. When he entered the cell, the HCO saw the man lying on the floor and CPR being carried out by the nurse and Hotel 5. The HCO gave them the airway device. The defibrillator was attached to the man by way of pads placed onto his chest. It automatically checked for signs of a heart rhythm that could be shocked. CPR had to be stopped to allow the defibrillator to be used; it indicated that there was no shockable rhythm and so CPR resumed.

80. The HCO was asked how long he thought he and the other medical staff worked on the man before the paramedics arrived. He found this difficult to answer as he had been focused on treating him, so was not aware of the time that had elapsed. The ambulance is recorded as having arrived at the prison gates at 6.18pm. Hotel 5 thought it was around ten minutes after he had arrived at the cell that paramedics and ambulance staff arrived.

81. Prisoners on C wing were still unlocked when the paramedics arrived, but shortly afterwards they were told to return to their cells. The man's friend told my investigator that, as the man's close friend was very upset by what was happening to him, they were placed together so that he could support him.

82. An initial response paramedic was the first to arrive. Hotel 5, who continued to administer CPR, said that at one point the oxygen ran out. The paramedic provided more and also gave the man an injection of adrenaline. Hotel 5 added that, when the other outside medical staff arrived, they took over treating him but he remained in the cell. He told the paramedics that staff had been administering first aid for at least 15 – 20 minutes. The paramedics continued to administer CPR for a further ten minutes but the man failed to respond. He was pronounced dead by the paramedics at 7.04pm.

Actions following the man's death

83. The two officers's along with the wing SO, had already left the cell and were in the office on the second landing. The Deputy Governor told my investigator that he spoke to the three staff before they went off duty as they had been directly involved. He said that all three were very upset when he told them that the man had died. He asked them whether they had any immediate concerns and one of the officers said he was concerned about the healthcare response.

84. The security PO and the prison chaplain went to see the man's close friend, who was still in the cell with the other prisoner, and broke the news of the man's death. Due to concerns about his wellbeing, the friend was moved into the Listeners suite. (Listeners are prisoners who volunteer to be trained by the Samaritans to provide confidential emotional support to fellow prisoners in distress. Many prisons have dedicated cells or rooms allocated on individual wings that can be used by Listeners to spend time with those in need of their assistance.) In addition, staff placed a number of prisoners who had been close to the man and were upset by his death on ACCT monitoring, including both his friends who had been with him. However, one of the man's friends told my investigator that he did not feel he needed this support and asked for the monitoring to be stopped the following day.

85. A governor was appointed as the prison's Family Liaison Officer (FLO). The man had not nominated a next of kin but, after speaking to one of his friends, the governor established that the man had been in contact with his sister who lived in the London area. He obtained the contact details from the prison telephone system and telephoned his sister at 10.15pm, three hours after his death. The governor informed the family of the man's death and arranged to visit them two days later on 4 October with the prison chaplain. The governor of Wakefield sent a letter of condolence to the family on 3 October. The prison had offered to visit earlier but the man's relatives wished to have time to ensure that all members of the family could be present.

86. During the visit to the man's sister on 4 October, the governor and chaplain also spoke with his father and brother. The governor told them about the events leading up to the man's death, as they were known at that time, and the investigation that would be undertaken by my office.

87. The man's family asked the governor a number of questions. First, they asked whether the man had completed the Sex Offender Treatment Programme (SOTP). They were told that he was still attending the course when he died. (The Head of Offending Behaviour Groups, told the chaplain that the man had a very positive session on the morning of his death and was doing well, having nearly completed the course.) His family also asked whether he had intended to appeal against either sentence or conviction, but he had not. Information obtained during my investigation also indicated that he had continued to smoke, another question raised by his family.

88. The family expressed a wish to visit the prison and attend a memorial service to be held by the chaplain. The family also asked the chaplain if he would officiate at the funeral, which he agreed to do. The chaplain discussed their wishes for the service including the music that they would like to be played. At the request of his family, the governor and C wing manager attended the funeral. The memorial service at the prison was held on 17 November and attended by his family, as well as the man's friends from both C wing and other parts of the prison. The family expressed their appreciation to my FLO, for the way the prison treated them following the man's death.

89. As part of the police investigation into the man's death, a detective constable of Wakefield CID, and the governor visited the man's family again on 17 January 2009 to clarify a number of points raised during earlier interviews. His sister told the DC that, when her brother was imprisoned, he had contacted the family and asked them not to visit. However, he kept in touch via telephone and letters. Due to the concerns raised during the police investigation regarding Sean's possible allergy to nuts, the DC asked whether the family were aware of him having any such allergies. The man's sister said that she did not recall him having any allergies to anti-biotics or nuts, but said that he had been prone to panic attacks and she remembered him carrying an inhaler to alleviate his symptoms.

Post mortem findings

90. At my investigator's request, HM Coroner, sent a copy of the post mortem and toxicology report on 2 January 2009. A Consultant Pathologist to the Home Office conducted the post mortem. Immediately after the man's death, there had been speculation amongst those who had known him and had contact with him on the day of his death that he might have suffered a severe allergic reaction due to a nut allergy. This is addressed in his report.

91. The pathologist concludes that:

> "...The pathological findings in this case indicate that the man died as a result of respiratory obstruction, consequent upon severe laryngeal inflammation. The inflammation had progressed to abscess formation.
>
> It is likely that the inflammation will have been caused by an acute bacterial infection. There is no evidence of any specific infection, such as tuberculosis.
>
> I consider the possibility that the inflammation of the larynx could have been a result of anaphylaxis (an acute allergic reaction.) The pathological findings (examination of the body) were not typical of this. This is also excluded by the results of the immunological studies (effects on the immune system).
>
> Shortness of breath resulting from severe laryngeal inflammation is a medical emergency and it is well recognised that it can cause fatal obstruction of the upper airway. If there is any issue relating to the standard of care at the prison, it will be appropriate to seek the opinion of an expert in a relevant speciality, such as ENT (Ear, Nose and Throat) surgery.
>
> There is no other natural disease that will have contributed in any way to causing death.
>
> There are no injuries or other marks anywhere on the body to suggest that the man had been subjected to any form of physical assault prior to his death. Those small injuries that were present are consistent with the effects of a terminal collapse [this refers to the fall that he had on the landing or to his final collapse in his cell] ..."

ISSUES

Response to code blue calls

92. The investigator asked Hotel 5, who attended all the code blue calls to the man, what equipment he had taken with him on these occasions. Hotel 5 explained that he had not taken any equipment as he saw his role as first responder and, after assessing the patient, he would ask his colleagues to bring any equipment that he thought necessary. I believe that this practice could potentially lead to an unnecessary delay in a prisoner receiving urgent medical treatment. The code blue informs medical staff that a prisoner is having some form of respiratory difficulty, and should therefore immediately indicate the type of medical equipment that might be required. During interviews with healthcare staff, the investigator established that bags containing the necessary equipment for such emergencies are held in the treatment areas on the wings and are easily accessible. I therefore make the following recommendation:

The Head of Healthcare should instruct medical staff allocated the call sign Hotel 5 that they should always take emergency equipment with them when responding to emergency calls.

Medical treatment

93. One of the clinical review team concluded:

> "… I feel that the man's death was due to the sudden onset of a rare condition, which could not have been anticipated. The diagnosis of which would have been unreasonable for an experienced general practitioner to make and to be compounded to a degree by his history of anxiety and agitation."

94. The clinical reviewer makes the following recommendation which I endorse:

There should be further assessment of the training given to healthcare officers in how to obtain a reassessment of a patient's condition where the symptom pattern does not follow its anticipated course, or earlier advice given by medical or nursing staff.

95. A nurse who carried out a review of the nursing care provided to the man concluded:

> "… From the information given it is clear that all healthcare staff administered appropriate assistance at the final code blue for the man and every attempt was made to resuscitate him. It is recognised as a difficult and distressing time for all concerned and I would recommend that the issues regarding prisoners and staff being at the scene or in close proximity of such situations is totally inappropriate and needs to be addressed.

> "The support and reassurance the first HCO offered to the man from the point of seeing the doctor to returning to the wing and attempting to support him at this time was an example of good practice.
>
> "Healthcare staff receive training in first aid and have been trained on all equipment and its correct use. All healthcare staff are now in the process of identifying any training needs that they have to maintain their professional development in line with the requirements of clinical governance …"

I concur with the reviewer's view that the HCO's actions in support of the man represented good practice and I commend him.

96. The reviewer makes two further recommendations in addition to that of her colleague. I have added to and endorse these:

The Governor should remind Orderly Officers about the importance of managing the scene of a medical emergency. In particular, the importance of ensuring that unnecessary staff and prisoners are moved out of close proximity to allow medical staff access.

The Head of Healthcare should ensure that, as part of the ongoing personal development review, staff are offered in-depth training in appropriate management of panic attacks, as these can often mask deeper physical and emotional health issues.

97. Following the issuing of the post mortem report and the advice of the pathologist, Wakefield PCT asked a Consultant Ear Nose and Throat Surgeon, MidYorks NHS Trust, to give his opinion on the diagnosis made by the prison doctor. The specialist makes some observations that both Wakefield PCT and the prison healthcare team might find useful. I urge them to read his full report, which is attached to the clinical review. In summarising his report the specialist says:

> "This is a rare condition and is unlikely to be one previously experienced by any of the staff involved. As a specialist in ENT, this is a challenging condition, let alone for someone without experience of it. The events described can, and have, occurred in hospital even with more experienced healthcare professionals. The important issues are whether there are measures possible to avoid a similar problem in the future and whether there was negligence.
>
> I do not believe there was negligence as I believe the individuals concerned did what any other similarly trained healthcare professional would do in similar circumstances …"

98. Some of the specialist's findings are akin to those in the report commissioned by Wakefield Police and completed by another Consultant ENT Surgeon. However, as I have indicated earlier, there are also significant differences.

99. The specialist says clearly that he believes there was no negligence on the part of healthcare staff at Wakefield. This conclusion is in complete contrast to the report of the police specialist who suggests:

> "... The prison doctor made several errors in her management of the man, and her failure to provide proper treatment was a significant factor in his death ..."

100. Following the completion of the report by the specialist, Wakefield Police concluded that whilst there was no case for criminal negligence. Their investigation was therefore concluded and their findings submitted to the Coroner along with the report completed by the specialist.

Prison Family Liaison

101. The prison, in particular the appointed governor, acted quickly to identify and inform the man's next of kin of his death. However, the initial contact was made by telephone and good practice would be to do this in person. Where this is not possible, a prison should consider the use of either another prison closer to the next of kin's address or the police. Nonetheless, his family have not mentioned that they felt any less supported because they were first told by telephone. The governor visited the family on more than one occasion and went with the investigating police officer to offer additional support to the family. The family mentioned to my FLO, that the prison had been clear from the beginning about the amount of the contribution they would make to funeral expenses. This saved the family financial worry at a sensitive time. I wish other prisons were so open and highlight this as good practice that could be used to encourage learning elsewhere. However, I also take this opportunity to remind the Governor of the importance of ensuring that the correct guidance is followed in respect of notifying next of kin.

Family response to draft report

102. Following the publication of my draft report my FLO, contacted the man's sister to obtain the family's feedback on the report.

103. His sister had a number of concerns but in conclusion said that she had been left with the view that some staff neglected her brother because they persisted in making assumptions about what he was telling them. She feels there should have been more urgency to their responses and even if they had continued to believe, he was having a panic attack/s they should have responded to his clear distress with more speed.

104. She understands the constraints there must be in prisons but feels he might have stood more chance of survival if he had not been a prisoner at the time. The man's sister feels that his chances would have been better if it had not taken 1 hour 5 minutes to get him emergency medical treatment.

CONCLUSION

105. Any death in custody is upsetting for those involved but particularly so in a case where the deterioration was as rapid as it was in this case. Wing staff and prisoners who witnessed this deterioration said that they felt that more could have been done medically. Indeed, the report by the specialist calls into question the actions of the prison doctor. However, having considered the report from the clinical review team and on the basis of my own investigation, I am satisfied that the medical staff on the wing acted appropriately based on the symptoms and information available to them at the time.

106. The two differing specialist reports will undoubtedly add to the concerns of the man's family. However, I am sure that the Coroner will look closely at the two reports and there will be a further opportunity to weigh up their findings.

RECOMMENDATIONS AND GOOD PRACTICE

1. The Head of Healthcare should remind all medical staff allocated the call sign Hotel 5 that they should always take emergency equipment with them when responding to emergency calls.

   Following publication of my draft report the Prison Service accepted this recommendation and said:

   Local Notice to Healthcare Staff to be issued highlighting this point/recommendation. Also to be included in July functional briefing.

2. There should be further assessment of the training given to healthcare officers in how to obtain a reassessment of a patient's condition where the symptom pattern does not follow its anticipated course, or earlier advice given by medical or nursing staff.

   Following publication of my draft report the Prison Service accepted this recommendation and said:

   In respect of Healthcare Officer training, they like all other Healthcare staff attend the annual, Defib/Resus training. This covers all aspects of dealing with medical emergencies. Notice to be issued to all Healthcare staff that in the event of a medical callout that does not appear to be following its anticipated course, then an immediate referral to a senior nurse or GP should be made.

3. The Governor should remind Orderly Officers about the importance of managing the scene of a medical emergency. In particular, the importance of ensuring that unnecessary staff and prisoners are moved out of close proximity to allow medical staff access.

   Following publication of my draft report the Prison Service accepted this recommendation and said:

   Local Notice to Staff to be issued reminding all staff including Orderly Officers the importance of clearing the scene of unnecessary staff and Offenders in order to be able to deal with a medical emergency.

4. The Head of Healthcare should ensure that, as part of the ongoing personal development review, staff are offered in-depth training in appropriate management of panic attacks, as these can often mask deeper physical and emotional health issues.

   Following publication of my draft report the Prison service partially accepted this recommendation and said:

   Head of Healthcare shall liaise with local PCT to see what training is available to meet this recommendation. There is no internal training

available to meet this recommendation, so it will have to be sourced externally via our NHS Partners

Good Practice

1. The support and reassurance the HCO offered to the man from the point of seeing the doctor to returning to the wing and attempting to support him was an example of good practice.

2. The prison was clear from the beginning with the man's family about the amount they would contribute to funeral expenses. This saved the family financial worry at a sensitive time. I wish other prisons were so open and highlight this as good practice that could be used to encourage learning elsewhere.