Investigation into the circumstances surrounding the death of a prisoner at HMP Stafford, in February 2008

Report by the Prisons and Probation Ombudsman for England and Wales

May 2009

This is the report of an investigation into the circumstances surrounding the death of a prisoner at HMP Stafford. The man died in February 2008 whilst a patient in a District General Hospital, having been admitted there following a collapse in his cell two days earlier. There was no post mortem carried out, and the Coroner accepted the cause of death as being due to pneumonia with ischaemic heart disease. His illness seems to have been brought on by an outbreak of influenza in the prison. The man was only 48 years of age when he died.

This investigation was carried out by one of my colleagues. I would like to add my personal condolences to the man's family and friends to those already expressed by my investigator and by one of my family liaison officers.

I thank the Governor of HMP Stafford and his staff for their help and co-operation during this investigation. I am also grateful to the South Staffordshire Primary Care Trust who commissioned a clinical review undertaken by a panel. A panel member also gave my investigator help and guidance in understanding some of the clinical issues raised by the review.

In addition to the three recommendations and one point of good practice of my own in this report, I would like to highlight the recommendations and good practice contained in the clinical review.

The issuing of this report has been delayed in part by the clinical review, but I must apologise to all those affected.

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

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SUMMARY

The man arrived at HMP Stafford in April 2004 having been in custody since July 2002. He had been sentenced to ten years imprisonment, with an additional five years on licence.

The man's initial health screening indicated that he was a heavy smoker, obese and an insulin dependent diabetic. He was also prone to mood swings that resulted in him banging his head against the cell walls and door. During his time in custody, he was subject to Assessment, Care in Custody and Treatment processes (the Prison Service's system for supporting and monitoring prisoners in crisis aimed at keeping them safe) on at least 13 occasions. Although staff found the man challenging at times, he appeared to be someone who was well liked by both staff and prisoners.

Towards the end of January 2008, a number of prisoners at Stafford started to suffer from flu-like symptoms. This eventually became an epidemic outbreak of influenza virus (B) that saw something in the region of 90 prisoners affected over the following few weeks. On 4 February, the man also started to show signs of being affected. He was assessed by a doctor in the morning of that day and prescribed antibiotics. Later that day he collapsed in his cell. Staff were sufficiently concerned to call for an ambulance straightaway, and the man was admitted to a District General Hospital.

By that evening, the man was considerably worse and had developed pneumonia. The hospital advised that the man's family should be asked to attend the hospital. They arrived at approximately midnight, but by this time the man had been put into a chemical coma (made unconscious using drugs) and was being supported by life saving equipment.

Over the next 30 hours, the man continued to deteriorate. His kidneys failed and he eventually died at 9.30am on a day early in February 2008.

THE INVESTIGATION PROCESS

1. My investigator visited HMP Stafford on 19 February 2008. He was given access to the man's prison records including his medical record. My investigator visited the unit where the man had been resident prior to admission to hospital. He was able to talk informally with several members of staff who knew the man, including the acting health care manager at the time.

2. My investigator also made arrangements to speak with representatives of the Independent Monitoring Board (IMB) and the Prison Officers' Association (POA), but neither felt they needed to bring anything to his attention. (Each prison has an Independent Monitoring Board. IMB members are independent and unpaid. They monitor day-to-day life in the prison and ensure that proper standards of care and decency are maintained. The IMB produces an annual report on the prison.)

3. Notices of my investigation were on display around the prison for staff and prisoners. As a result of these notices, three prisoners wrote to my office offering further information about the care received by the man whilst in the custody of HMP Stafford. My investigator interviewed two prisoners in September 2008, one of whom had written earlier in the year. Unfortunately, two prisoners who had written to me had been released from prison by the time my investigator was able to conduct his interviews. However, they had, communicated their main concerns to one of the prisoners who was interviewed.

4. South Staffordshire Primary Care Trust was asked to undertake a clinical review of the care the man received while in custody. A panel undertook this task. The panel's report provides a comprehensive understanding of the care the man received whilst in custody at Stafford, although the process was subject to considerable delay. The panel concludes that the healthcare provided to the man was at a level equivalent to that which he might have expected to have received in the community, "if not at times exceeding it".

5. My investigator contacted HM Coroner to inform him of the nature and scope of my investigation and to request a copy of the post mortem report. However, because the man died in hospital, the Coroner thought it unnecessary to have a post mortem. He was content to accept the cause of death as reported by the hospital, which was pneumonia as a result of ischaemic heart disease. The Coroner proceeded with his inquest on 30 June 2008. The jury found that the man died of natural causes.

6. The man's sister and son were present at the inquest and they met my investigator there. They raised an issue regarding the cancellation of a visit they made to the man on the day he was admitted to hospital. They found it difficult to believe that he refused to see his family, and wondered if something else had occurred that meant he was refused the opportunity to go to his visit. My investigator agreed to look into this matter.

7. One of my Family Liaison Officers contacted the man's family early in March 2008. The family later requested that the man's sister be the main point of contact for the family, in view of his mother's failing health. The family raised four main concerns which I endeavour to deal with within this report. The first was the delay in informing them that the man had been taken into hospital, and the second was an issue regarding a bunk bed being put into the cell the man occupied. The family also asked why the man's pain relief was stopped suddenly with no explanation. Finally, the family wanted to know why the man had been asked to share a cell when he was reported to be claustrophobic. I hope that this report goes some way to answering the family's concerns.

8. The prisoners who were interviewed expressed two main concerns. These were that the man's diaries had been inappropriately disposed of and that other prisoners had had the opportunity to read them. The second concern was that the man's claustrophobia, in conjunction with the installation of the bunk beds in his cell, led him to sleep on the floor. The prisoners are of the view this led to him contracting pneumonia which in turn led to his death.

HMP STAFFORD

9. HMP Stafford was built in 1794 and, apart from the period 1916-1940, has been in continuous use as a prison ever since. It holds 721 category C prisoners. The man was located on F wing which can accommodate up to 155 vulnerable prisoners over four landings. The bottom landing accommodates 24 prisoners in single cells. All prisoners on the wing are expected to work unless there are medical reasons they cannot do so, or unless they are past the retirement age.

10. There is a medical hatch on the ground level landing between E and F wings. E and F wings also share a full-time nurse who oversees the medical needs of prisoner-patients on the wings, administers treatments, and sees prisoners on the wing throughout the day as necessary. There is no in-patient healthcare facility at Stafford.

11. HM Chief Inspector of Prisons issued her most recent inspection report about Stafford in July 2006. The Chief Inspector said that Stafford was a much improved prison, but there was still a lot more that could be done to make it an effective training prison. In respect of mental health services, the Chief Inspector noted that the primary mental health team included three RMNs (one on long term sick leave) and one RMN-qualified healthcare officer. This team provided support to those with mental health problems who did not fulfil the criteria of the in-reach team but needed mental health support. It also acted as the point of access to the mental health in-reach team. (The man received support from both primary mental health services and the occupational therapist from the in-reach service.) The Chief Inspector reported concern that in-reach staff were prevented by their own Trust from being given keys, and this had an impact on the services delivered to patients.

12. The Chief Inspector of Prison's report noted an area of good practice in respect of healthcare services that applied to the man. She wrote:

> "The care of diabetic patients was well managed. The nurse responsible for this area maintained a register of all diagnosed diabetic patients in the prison. Records relating to the diabetic care of these patients were clear and well maintained. Prisoners were encouraged to be involved in the management of their condition and to share responsibility for their care. The nurse had also worked with catering staff to ensure that appropriate menus and snacks were available for diabetics, distinguishing between the different needs of type I and type II diabetics."

13. On 8 February 2008, the Health Protection Agency issued a press notice about HMP Stafford as follows:

> "Public health doctors from the Health Protection Agency (HPA) and the South Staffordshire Primary Care Trust are investigating an outbreak of influenza at Stafford Prison. To date over 90 prisoners on one wing of the prison and some staff have been affected by the

illness. Tests on isolates sent to the Health Protection Agency laboratories have proved positive for influenza B.

"Sadly, a prisoner from the wing has died in hospital of pneumonia with complications. The man fell ill ,,, and was transferred to hospital, where he died the next day. Doctors are working to try to determine if flu played a contributory part in his death. Another prisoner was admitted to hospital … where his condition is stable and he is expected to make a full recovery."

14. The HMP Stafford Independent Monitoring Board's report for 2007-2008 said that the Board welcomed the signing of service level agreements for healthcare provision, but wanted to see additional resources - especially for counselling services.

15. There have been four deaths from natural causes of prisoners at Stafford since I was given responsibility for investigating all deaths in prison custody in 2004. There are no similarities between the findings and recommendations made in this report and those following my earlier investigations.

KEY FINDINGS

16. The man was first remanded into custody at HMP Shrewsbury on 30 July 2002 by Cannock Magistrates Court. His initial health screening indicated that he was an insulin dependent diabetic, obese, suffered from claustrophobia, and was a heavy smoker. In the past he had also been a heavy user of cannabis.

17. Whilst on remand at Shrewsbury, the man was attacked by another prisoner which resulted in his ankle being broken and a subsequent transfer to HMP Blakenhurst (now rebadged as part of HMP Hewell). He remained at Blakenhurst throughout his trial and sentencing. In January 2003, the man received a sentence of ten years, with an extended licence of five years following release. During his time at Blakenhurst he shared a cell with the first prisoner, with whom he got on very well. In interview, the first prisoner spoke of the two men being supportive to each other and sharing confidences, and that he and the man got quite close. Indeed, when the man was transferred to HMP Stafford a few months after the first prisoner, they resumed their mutual support by sharing a cell together.

18. Just days after being sentenced, the man was considered to be at risk of self-harm and a form F2052SH was instigated. (F2052SH was the Prison Service's then system for supporting prisoners judged at risk of self-harm. It has been superseded by the Assessment, Care in Custody and Teamwork [ACCT] process.) It was thought by staff at the time that the man was reacting badly to his conviction and lengthy sentence.

19. The man was again placed on an F2052SH on 3 July 2003 when he felt angry at 'being stitched up'. He reported in his F2052SH reviews that he had a tendency to act impulsively and that the trigger for his behaviour on this occasion had been contact with his ex-wife. This led him to be upset, and threatening to harm himself.

20. F2052SH procedures were again started on 19 February 2004 when the man reported waking up on two separate occasions with a noose around his neck. However, in his review meetings, the man said he did not know why the noose was there.

21. The man transferred to Stafford on 30 April 2004 and seemed to be settled. However, on 10 March 2006 he was thought to be sufficiently distressed to require an ACCT being opened to keep him safe. The documentation refers to ongoing health difficulties (although it is not clear what these were specifically).

22. On 3 April 2006, the man was in such acute distress that it was thought safer to transfer him to HMP Birmingham where he was put under constant supervision. (This meant that a member of staff sat outside his cell all the time observing him.) Despite this, he attempted to hang himself on the next day.

23. The man was thought to be feeling much better by 10 April, and he therefore returned to Stafford. He was prescribed a change to the insulin for his diabetes and an anti-depressant (Venlafaxine) for his depression.

24. On 17 May 2006, the man spent two days in Queen Elizabeth Hospital, Birmingham, where he underwent surgery on his teeth. He was reported to feel much happier following the operation.

25. Throughout the summer of 2006, the man was seen by the mental health team who supported him with counselling and occupational therapy sessions. As part of the therapy, the man was asked to keep a diary of his feelings and thoughts. Despite this support, the man would often resort to banging his head against the walls or door of his cell when things got difficult or frustrating for him. However, it does not appear that it was necessary to open another ACCT document for the man until the following August (2007).

26. An entry in the clinical record dated 27 July 2006 by the occupational therapist indicated that the man was feeling low in mood, tearful, and had suicidal thoughts although he denied any plans for killing himself. He said that the anti-depressants were not working. The occupational therapist did not think it necessary to open an ACCT document, but said in the clinical record that the man would need increased support whilst he was feeling vulnerable.

27. The man was notified on 22 December 2006 that his application for release on licence had been refused by the Parole Board.

28. Throughout 2007, the man seems to have been relatively well settled and to have worked in the prison workshops. He attended a Coping Skills course in November and was on the enhanced regime under the prison's Incentives and Earned Privileges scheme. (This is a scheme to encourage and reward good behaviour. There are three levels to the scheme – basic, standard and enhanced, with enhanced being the highest level.) However, in August he was again put on an ACCT (because of his frustration at the way legal matters regarding his sentence were being handled). Once he had been in contact with his solicitors, he settled down and the ACCT document was closed.

29. On 2 November 2007, after being rebuked by a member of staff for being in someone else's cell when he should not have been, the man started banging his head against the cell wall. The ACCT process began again, but was concluded the following day.

30. The man was moved on 9 December from workshop 2, where he had been working since he first arrived at the prison, to a job in the prison's reclamation unit. The new post meant that the man would get more fresh air and exercise, something that had been recommended for his health. He appears to have welcomed this change.

31. The man refused to take his prescribed medication on 22 December 2007, after he had been discovered 'palming' his Tramadol tablets (trying to hide his tablets instead of taking them in front of staff). On the same day he was seen

by nursing staff because he felt unwell. His blood sugar reading was 22.4mmols (this indicates high blood sugar), even though he reported that he had taken his diabetic medication correctly. The man also complained of chest pain, although this had gone by the time nursing staff reviewed him. He had pains in his knees and legs for which nursing staff gave pain relief tablets.

32. The medical record says that the man had chest pain over the weekend of 24 December, and also had shortness of breath on exertion for about 15 minutes before it subsided. He reported that the chest pain was in the left side of his chest, and that it had not spread anywhere else in his chest or arms. He was prescribed a 14 day course of pain relief (Naproxen 500mgs to be taken twice a day).

33. The man complained of a cough and sore throat with flu-like symptoms on 4 January 2008. He began a one week course of antibiotics (Erythromycin 250mgs to be taken four times a day).

34. Healthcare staff were called to see the man in his cell on 15 January 2008 because he had head-butted and punched the cell wall. This was in frustration and protest at the placing of another bed in his cell to form bunk-beds. The man explained that he was claustrophobic and the imposition of bunk-beds made him feel anxious and suffer panic attacks. He reported that he had been sleeping on the floor. The records say that he was tearful and had abrasions to his forehead and bruising to the knuckles of his left hand.

35. On 16 January, the man was assessed by the prison doctor, who reviewed the previous day's events and reports from prison staff that he was refusing to eat. When the man arrived in the healthcare department, he was reported to have immediately returned his glucometer (a devise for measuring blood sugar levels) and his blood glucose diary, saying 'you can have these back'. These actions were apparently due to his anger about the bunk-beds.

36. In the last few days of January, a number of prisoners at Stafford started to develop flu. Over the following few weeks, there developed what was described by the media as an epidemic outbreak of flu, with up to 91 prisoners being affected.

37. At about this time, as a temporary measure, the man was moved from his regular cell to a crisis cell, because it is closer to the wing office and only had a single bed in it.

38. One morning in early February, the man reported that he too felt unwell and had flu-like symptoms. His medical record says that he had a cough which produced green phlegm, although his chest was reported to be clear. He started another course of Erythromycin and was advised to rest in his cell.

39. The man was reported to have collapsed in his single cell later that afternoon. Nursing staff were called and found him conscious but lying on the floor in the toilet area of his cell. Two nurses arrived and took the man's vital signs (blood pressure, pulse, rate of breathing) and questioned him about what had

happened. He appeared sweaty and one of the nurses remembers the man's vital signs were all a little off normal (his pulse was slightly too fast, his blood pressure slightly high, and his breathing a bit fast). The nurses both thought it was necessary to call for an ambulance.

40. When the ambulance arrived, the paramedics decided to take the man to hospital. They left the prison at 5.00pm with the man and two prison officers escorting him. When they got to the District General Hospital, the escorting officers were asked to remove the handcuffs so that the doctors could examine the man more easily. They did so, and applied an escort chain instead. (An escort chain is a long chain with a handcuff at both ends. The officer is attached to the prisoner via this chain to enable the use of a toilet or to allow medical examinations when the prisoner is in hospital. It is often used when a prisoner is confined to bed in hospital as it allows greater freedom of movement.)

41. During that evening, it became increasingly clear that the man was extremely unwell. Oxygen was given and he drifted in and out of consciousness whilst nursing and medical staff performed various tests, including blood tests and x-rays. At one point, hospital staff wondered if the man might have taken something illicit at the prison, but there was no indication that this was the case. The only additional information available to the escorting officers was that prison staff reported that the man had refused a visit from his family that afternoon.

42. At 10.00pm, nursing staff asked prison staff to obtain next of kin details for the man. They did this via the duty governor at the prison and nursing staff spoke to the man's mother at approximately 10.45pm.

43. The doctors at the hospital thought it necessary to make the man unconscious by using drugs and to move him to the Intensive Care Unit. The escorting prison officers asked the duty governor for permission to remove all restraints and permission was granted.

44. The man's family arrived at approximately midnight, by which time he was already unconscious. They were initially only able to stay with the man for a short time, because the nursing staff were still working to make him comfortable, inserting catheters and drips and ensuring the machines were working properly. Eventually, at 1.50am, the man's mother and his son were able to sit by his bedside with prison staff in attendance at a distance. The man's family left at 2.30am.

45. Throughout the rest of that day and the following day the man continued to deteriorate. He developed pneumonia and his kidneys started to fail. His family were able to come and go as they pleased. Despite the efforts of medical staff, the man passed away at 9.30am early February, 2008. He was 48 years old.

ISSUES

46. The man was diabetic and dependent on insulin. The clinical review panel has examined whether the man received the same level of care that he might have expected had he been in the community. They conclude that he actually received 'a high standard of diabetes care … whilst in the care of HMP Stafford'. However, despite being strongly advised to lose weight and give up smoking, the man ignored this advice and would frequently ask other prisoners for their unwanted puddings. In interview, the prisoner who had shared a cell with the man, told my investigator how the man would make bets with other prisoners about such things as winning at pool, the payment for which was usually in Mars Bars. (This is common practice amongst many prisoners).

47. The man used to bang his head frequently against the cell wall and door if he felt frustrated, anxious or angry. The mental health support services were well used to helping the man through these crises, and staff on the wing would sometimes decide to open an ACCT document (or its predecessor form). Again, the clinical review team consider that the man's mental health needs were properly identified and managed.

48. The exception to this concerns the events of 27 July 2007 when the man was seen by the occupational therapist and reported feeling depressed and suicidal, but did not have any proper plans as to how he might kill himself. It does not appear that an ACCT document was thought necessary at the time. (The clinical review makes the recommendation that all members of the multidisciplinary team should be aware of the ACCT process and the procedure for opening an ACCT form.)

49. The man's family raised the issue of his pain relief being stopped. It appears from the medical records that his prescription for Tramadol was stopped in December 2007 because of the incident where he was found to be secreting his tablets. According to his medical record, this was not the first time he had been caught doing so. The man was initially very unhappy that his Tramadol was stopped and he threatened not to take any medication, including his insulin. It seems that, after a few days, he settled and accepted that he would not receive Tramadol again. There is no record of the man being prescribed any more regular pain relief.

50. The event that seems to have caused the man and his family most distress was the installation of an additional bed in his cell to create two bunk-beds. It was part of an agreement the Governor had made with the Prison Service's Area Manager for West Midlands to increase the potential capacity of the prison. The man's family were aware of the distress this caused him and they took the trouble to telephone to inform prison staff (staff already knew of the problem because of the man's head banging behaviour). A number of staff tried to reassure the man that he was not expected to share his cell, merely accept that there were to be two beds in his cell in line with the Governor's instructions

51. Despite the reassurances, the man continued to bang his head in frustration. He refused food and refused to monitor his blood glucose levels (it is not thought that he actually refused to take his medication). The extra bed still made the man feel claustrophobic and he took to sleeping on the floor because he felt hemmed in by the bed above him when he slept on the lower bunk.

52. I cannot be certain about what motivated the man to behave in this way. Indeed, I note that when he was at Blakenhurst, and in his early days at Stafford, he had been happy to share a cell with another prisoner. I believe that wing staff did their best to help the man, even moving him into a safer custody cell (a cell without a bunk bed in it although safer cells can also be double occupancy cells) in his last few days in the prison. Although this was a temporary move because he felt unwell with flu-like symptoms, I am confident that prison staff tried to help the man under very difficult circumstances.

53. Whilst the man was under the care of the mental health services, he was asked to keep a diary as part of his therapy. When my investigator spoke with prisoners who had asked to see him about the circumstances surrounding the man's death, two of them specifically wanted to tell him about those diaries. They told my investigator that, after the man died, the diaries had found their way to the reclamation or recycling area of the prison and had been read by prisoners working there.

54. My investigator asked prison staff to provide the 'cell clearance' log for the man's cell following his death but they were unable to provide one. (Cell clearance forms are usually completed by staff when a prisoner has been moved without notice or has not been given the opportunity to pack his own belongings. The cell should be closed after the prisoner's departure and then re-opened when staff arrive to pack the items in sealed bags. The correct procedure is for the officers to obtain the prisoner's property card [a record of all property brought or sent into a prison] from reception first, noting down the quantity, description and condition of each item. If items on the property card are not found in the cell, these should be recorded, as should items found in the cell but not listed on the property card. Cell clearance forms should also record the date when the cell was cleared, the names and signatures of the staff and the seal numbers for the bags.)

55. It appears that the man used to keep a lot of papers in his cell, and staff who cleared his cell may have thrown out the diaries with other newspapers and the like, not realising what they were. It has proved impossible to be certain the diaries existed, but I think it highly likely that they did. I also think it likely that they were disposed of in the manner described by prisoners. If so, this was wholly unacceptable. The personal property of any prisoner should be treated with respect. The personal property of a prisoner who has died should be treated with special care.

The Governor should write to the man's family apologising for the loss of his therapy diaries. He should remind staff of the correct cell clearance procedures, including record keeping.

56. I have been pleased to learn of the humane manner in which the man was treated after he arrived in hospital. After the initial request from hospital staff for the man's handcuffs to be removed, prison staff used their initiative and requested permission for removal of all restraints, including the escort chain. I have identified their actions as good practice, and would ask the Governor to commend the first prison officer and the second prison officer (from HMP Drake Hall), the staff involved in the bed-watch, for the professional way in which they considered the issue of restraints.

57. That having been said, the man's sister was disappointed not to have been told earlier that her brother had been taken into hospital. I appreciate that it can sometimes be difficult to balance security and concern for the rights of family and friends, especially when it comes to an admission to hospital. I also appreciate that not every person being admitted to hospital is critically ill, as the man turned out to be. I am aware that as soon as it became clear that the man was very poorly, efforts were made to contact his next of kin. Nevertheless, I recommend:

The Governor should ensure that arrangements are made between healthcare and security to identify when a prisoner's condition is sufficiently serious to warrant the notification of next of kin. The arrangements should identify who has the responsibility to notify the next of kin and should be communicated to those in charge of the prison at the time.

58. At the time of the man's death, Stafford prison was in the grip of an outbreak of flu that resulted in the Health Protection Agency being notified. The epidemic proved quite difficult to manage in a closed environment, but staff at Stafford took the advice of health professionals very early on. They isolated the wing where the outbreak had occurred (F wing) and screened all vulnerable prisoners under their care. Had the man not contracted flu when he did, it is impossible to say whether these measures would have prevented him from becoming so unwell. He was one of the first people to succumb to the flu virus and was part of the reason the HPA were contacted in the first place. He was also someone with added health complications as a consequence of diabetes, smoking and being overweight.

59. On the afternoon that the man was taken ill and collapsed, he was due to be visited by his family. The family were told that the man had refused his visit and they were therefore sent away. When my investigator met the family at the Coroner's inquest in June 2008, they made it clear that they did not believe the man would have refused his visit. During the course of this investigation, my investigator examined the visits system in place at Stafford. He was shown the booking-in system used to facilitate prison visits and the audit trail which shows who escorted each prisoner to the visits area, who searched them, which table they were allocated, and who came to visit them. In most respects the system is quite thorough. Visits staff were able to show my investigator the record of events for the day when the man's family came

to visit. The document contains an entry by the escorting officer that the man had refused his visit. No explanation for his refusal was recorded.

60. My investigator was told that the senior officer would normally question staff about the reason for a prisoner declining a visit, and would usually record the answer. On this occasion, no such record was made. Whether the man did indeed refuse the visit, perhaps because he felt so unwell, or whether he did not get out of bed quickly enough for the escorting officer to take him to the visits area, I am unable to say. I am sorry that I am unable to allay the concerns of the man's family that the prison failed to facilitate properly their visit to the prison on that day in February 2008.

The Governor should remind visits staff to make a full record of events concerning visits including comprehensive details of any reasons for a visit not taking place.

61. The man was someone with health complications who developed flu. Having collapsed in his cell, he was taken to hospital. He developed further complications whilst in hospital, leading to pneumonia and then multi-organ failure. The Coroner's inquest found that the man died of natural causes.

RECOMMENDATIONS

The Prison Service accepted all three of the following recommendations:

The Governor should write to the man's family apologising for the loss of his therapy diaries. He should remind staff of the correct cell clearance procedures, including record keeping.

The Governor should ensure that arrangements are made between healthcare and security to identify when a prisoner's condition is sufficiently serious to warrant the notification of next of kin. The arrangements should identify who has the responsibility to notify the next of kin and should be communicated to those in charge of the prison at the time.

The Governor should remind visits staff to make a full record of events concerning visits including comprehensive details of any reasons for a visit not taking place.

GOOD PRACTICE

The Governor should commend the first officer and the second officer, the staff involved in the bed-watch for the man, especially in respect of the professional manner in which they considered the use of restraints.

RECOMMENDATIONS AND NOTABLE PRACTICE FROM THE PCT CLINICAL REVIEW

All clinicians for commissioned services should be reminded of their professional obligations in relation to clinical record keeping.

All members of the multidisciplinary team (including commissioned services) should be aware of the ACCT process and, more importantly, the process for opening an ACCT document.

The high standard of clinical record keeping of South Staffordshire Primary Care Trust employees, which is in accordance with recognised professional standards, should be noted as an example of good practice.

The immediate response to the man after prison staff found him collapsed in his cell, the prompt arrival of members of the healthcare team and, subsequently, the Ambulance Service are commendable.

The high standard of diabetes care the man received whilst in the care of HMP Stafford should be noted.