

**Investigation into the circumstances surrounding the death of a man at
HMP Kirkham on 19 June 2005**

Report by the Prisons and Probation Ombudsman for England and Wales

May 2006

This is the report of an investigation into the circumstances of the death of a man at HMP Kirkham on 19 June 2005. He collapsed in the prison's gymnasium.

My office investigates the deaths of all prisoners in custody, including those due to apparent natural causes. In this case, the investigation was carried out by one of my investigators. She commissioned an independent clinical review from the local Primary Care Trust (PCT).

The man died of a coronary atheroma, less than two months into an 18-month prison sentence. He suffered from a chronic heart condition when he arrived in prison, and I do not believe that any action on the part of prison staff could have prevented his death. I offer my sincere sympathy and condolences to his wife and family for their loss.

I am grateful to the Governor and his staff for their assistance during the investigation. I am also grateful to the PCT for carrying out the clinical review of the man's care.

My report makes two recommendations.

Stephen Shaw CBE
Prison and Probation Ombudsman

May 2006

CONTENTS

Summary	4
The investigation process	5
Background	6
<i>The man</i>	
<i>HMP Kirkham</i>	
Key Findings	7
Time in custody before 19 June	
Events of 19 June	
Contact with the man's family	
Issues considered during the investigation	12
The man's use of the gym	
The location of the defibrillator	
Contact with the man's wife	
Recommendations	14

ANNEXES

- 1 Clinical review
- 2 Physical Education Record (F2055 D)

Summary

1. The man was born in 1958. He died on 19 June 2005 at the age of 47 of coronary atheroma (a condition that occurs when the arteries that carry blood to the heart become blocked). He had a history of cardiac problems before he was imprisoned, and was on long-term medication for his heart.
2. He spent his first two weeks in prison at HMP Altcourse in Liverpool. His heart problems were noted and his medications listed. He was put on the healthy options diet, and added to the waiting list for the smoking cessation programme.
3. On 5 May, he transferred to HMP Kirkham, an open prison in Lancashire. Again, his heart condition was noted and monitored, and he was put on the healthy option diet. He completed the gym induction the following day and, because of his heart problems, was advised not to take part in physical activities. However, he wanted to keep active - both to make the time pass more quickly and to maintain his health - and so he used the gym. He settled in well to life at Kirkham and quickly gained enhanced status on the incentives scheme.
4. At 5:55pm on Sunday 19 June, he was playing badminton in the gymnasium when he collapsed. The Physical Education Instructor on duty that day was a qualified first-aider. He is trained in the use of a defibrillator, a machine that treats victims of sudden cardiac arrest by delivering a shock to the heart. He immediately went to the man's aid and administered the GTN spray that he had in his pocket. This medication is used to open up the arteries and help the heart pump blood around the body. He then started mouth-to-mouth resuscitation. Another member of staff brought a defibrillator and he used this too. An ambulance crew arrived within eight minutes, but sadly their efforts at resuscitation were unsuccessful.
5. Managers at Kirkham decided that, because of the distance from the prison to her home, it would take too long for staff to go and break the news to the man's wife. They therefore asked the local police to visit her and tell her of her husband's death. However, the police did not arrive at her home until about 11:00pm. She was at work, so she did not learn of her husband's death until 11:30pm. A number of factors in the way the news was broken to her, and subsequent events, combined to compound her grief.

The investigation process

6. The investigation was opened by telephone on June 20. The following day, the Notice of Investigation and notices to staff and prisoners were posted. The prison sent all the man's prison records, including his medical records to my investigator. The records included the statements from staff who had been involved in the resuscitation attempts.
7. The investigator contacted the Chairman of the local branch of the Prison Officers' Association (POA) and the Chair of the Independent Monitoring Board (IMB). Neither had any issues concerning the man's death that they wished to draw to my attention.
8. One of my Family Liaison Officers (FLO) made contact with the man's wife. A meeting was arranged at which she and her mother raised a number of issues with the FLO and the investigator. I have tried to address these issues in this report and hope it provides some answers to them.
9. The local PCT arranged a clinical review of the man's medical treatment. The report is at Annex 2.
10. No formal interviews with staff were felt necessary. This report is, therefore, based on a thorough review of all the relevant paperwork, including the written statements made by staff, the man's prison records and the clinical review.

Background

The man

11. The man was serving an 18-month prison sentence for fraud when he collapsed and died in the gymnasium at Kirkham. It was his first time in prison and, in fact, his first offence. His wife told my investigator that her husband was full of remorse for what he had done, and was focussed on making his time at Kirkham pass as smoothly and quickly as possible. He had previously had two heart attacks and aimed to keep active, both to make the time pass more quickly and to look after his heart.
12. After spending just two weeks at HMP Altcourse, the man was transferred to Kirkham. He asked to work in the greenhouses and it was agreed that he would be employed in the garden and greenhouses. His supervisor noted that he worked hard and to a high standard without supervision. His personal officer recorded that he kept his room very neat and clean. After being at Kirkham for 28 days, he was given enhanced status which was the earliest date that this could be granted. Staff commented on how polite he was and his very positive outlook.

HMP Kirkham

13. Kirkham is a category 'D' open training prison with accommodation for around 600 adult males. It is a working prison with workshops, a farm and gardens. It occupies the site of a former Royal Air Force Technical Training Establishment that was built during the Second World War and used post-war as a major demobilisation centre. The Home Office took over the facility in the early 1960s and it has been used as a prison since 1962.
14. Since 1990, the original accommodation blocks have gradually been replaced with modern blocks each accommodating around 20 men. All prisoners occupy single rooms. Locking and unlocking of the main door to each block is controlled by prison staff, but prisoners hold individual keys to their own rooms with staff holding master keys.
15. The healthcare centre operates daily, and out of hours health care is provided by local Medical Services. A GP is available for two hours each weekday and also provides out of hours cover. A pharmacy technician, dentist, chiropodist and optometrist are employed on a sessional basis. Other services, such as medical screening, diabetes, asthma and mental health care are also available.

Key Findings

Time in custody before 19 June

16. The man was charged with obtaining goods by deception on 14 September 2004 and was given bail. On 22 April 2005, he was sentenced to 18 months imprisonment and was taken to HMP Altcourse.
17. During the reception procedures at Altcourse, the man was given a First Reception Health Screen. He told staff that he had suffered two heart attacks six years earlier, and he listed his current medication. He continued on the same medication throughout his time in prison. He was put on the healthy option diet and joined the waiting list for the 'Fagends programme'. This is a twelve-week support programme that includes nicotine replacement therapy to help prisoners to stop smoking. He also told staff that he had a forthcoming medical appointment, but no details of this appointment were recorded. The plan was to review him in six months, and until then to undertake blood screening and an electrocardiograph.
18. When questioned about his mental health, the man told staff that he had tried to harm himself three months previously whilst on bail, when he had been suffering from depression. He had seen a psychiatrist who had prescribed anti-depressants. However, he assured staff that he had no current ideas or thoughts of self-harm. Staff noted that he was, "Very positive in speech and manner." Because this was his first time in prison, reception staff referred him to a registered mental nurse whom he saw four days later. The notes of that meeting record that "He presented as calm and relaxed," and no follow up was planned.
19. On 5 May, the man was transferred to Kirkham. On arrival, he was again seen by health care staff in reception. As a result of his health problems he was given a reduced labour rating of 2B, which meant that he was restricted in his physical activity and labour allocation. He was also put on the healthy options diet.
20. The following day, the man went through the gym induction, during which he filled out a physical activity readiness questionnaire (PAR Q). On the form he recorded his heart condition, and the fact that he sometimes felt pain in his chest, both during exercise, and when not doing physical activities. He assessed his physical fitness as "active", which was the second highest level. For the level of activity he wanted to undertake, he requested "above average for age and condition". He selected cycling, squash and badminton as sports he would like to play in order to "exercise my heart" and "live longer". However, he was not willing to complete the weights room induction, and signed the form to show that he understood this prohibited him from using the weights room.

21. The final form completed was the sports centre action plan. The gym induction documents are at Annex 2. In the section for the plan, the Physical Education Officer (PEO) wrote, "Due to PAR Q no gym activities." The man signed the form beneath the declaration, "I confirm that I have had an input into the Action Plan and that all aspects have been clearly explained by the PEO". The PEO also signed the document.
22. On 10 May, the man had his blood pressure checked in healthcare. The records state that no other problems were noted.

Events of 19 June

23. On Sunday afternoon, 19 June, the man was visited by his wife. Afterwards, he went to the gym to play badminton. At Kirkham, the gym is very large and many men were using the facilities that evening. Shortly before 5:55pm, the man collapsed. The other prisoners immediately alerted the PEO on duty, who was in the office at the other end of the gym. The PEO went directly to the man, and saw that he was unconscious and his breathing was laboured. He put him in the recovery position, and went back to the office to call for a 'blue light' ambulance and the defibrillator. (A defibrillator is a machine that is used to stimulate a person's heart. It passes a current through to the heart to trigger it and return it to normal regular cardiac rhythm.)
24. The PEO returned to the man and spoke to him, but got no response. The other prisoners told him that the man carried medication with him. The PEO found a spray in the man's pocket that he sprayed into his mouth. He appeared to breathe more deeply, and then exhaled slowly. The PEO checked for, and found, a pulse. The man's head was falling forward, so he fetched a pillow from the office and put it under his head.
25. The PEO monitored the man's condition and again checked for a pulse, but could not find one this time. He then moved the man into the correct position for receiving mouth to mouth resuscitation and began the procedure. At that point, a senior officer arrived with the defibrillator which he had brought from the Communications Office. He was followed into the gym by an officer. The PEO is a trained first-aider whose training is up-to-date and he is also trained to use a defibrillator. He set up the machine and followed its instructions. The defibrillator twice ordered staff to stand back while it delivered a shock to the man, then to resume CPR. The PEO still could not find a pulse, so he continued doing mouth to mouth resuscitation and the officer began the chest compressions. Another officer arrived and he took over the compressions to allow his colleague to rest. The officers continued until the paramedics arrived. Other officers cleared the gym and sports field of prisoners, and ensured that doors were locked.

26. The Communications log shows that the call for an ambulance to attend the prison was made at 5:55pm, and it arrived at 6:03pm. An officer was waiting at the main gate to escort it to the gym to ensure that no time was wasted. When the paramedics arrived in the gym, the PEO briefed them and they took over the man's treatment. Sadly, they could not resuscitate him and at 6:05pm they confirmed that he had died.
27. The Duty Governor was immediately informed and he contacted the Governing Governor. Neither was at the prison that evening but they both went there, arriving at 6:35pm. The chaplain was already at Kirkham. She went to the gym where the officers who had carried out the resuscitation attempt had remained and spoke to them. The staff on duty attended a debrief at about 8:30pm.
28. The police were notified at 6:20pm and local police arrived at 7:00pm. CID officers subsequently attended at 8:05pm, followed by two scenes-of-crime officers at 10:20pm. The coroner's contracted undertakers arrived at Kirkham at 9:25pm and left 15 minutes later.
29. The following day, notices were put up in the gym and it was closed for the day as a mark of respect.

I am impressed by the prompt and professional actions of the PEO and recommend that the Governor formally commends him.

Contact with the man's family

30. Once it was confirmed that the man had died, the prison managers discussed how to inform his wife as quickly as possible. An important consideration was that prisoners at Kirkham have easy access to telephones. The managers wanted to ensure that she was given the sad news officially, rather than from a prisoner. However, the prison is almost 100 miles from her home, and managers felt that it would delay the news too much to send representatives from the prison. They assumed that the police in her area would know the district well, could reach her home and deliver the news personally much sooner than prison staff could. Therefore, at about 7:40pm, the police were asked to break the news to her. They were also asked to give the prison regular updates about what was happening, informing them once they had spoken to her.
31. The man's wife was at work from 9:00pm that evening, and she was already worried about her husband. He always telephoned her in the evenings after she had visited him to check that she had arrived home safely. That evening, she had not had a call and she was concerned that something had happened.

32. At around 11:00pm, two female police officers arrived at her mother's home. Her mother was there and gave them her work address. She asked to go with them as it was obvious to her that, although they refused to tell her anything, they were the bearers of bad news. They said that this was not possible. About 11.30pm, the officers arrived at the workplace, said they had news for her and asked if she wanted to be told immediately. She said no, got her coat on and left her workplace. Therefore, she learned of her husband's death in surroundings that were far from ideal. She was also very aware that the officers who broke the news of her husband's death were from the local police unit that had arrested him and this added to her distress. She asked the officers what time her husband had died, but they were only able to say that it was around 6:00 or 7:00pm.
33. Once she heard the news, her overwhelming desire was to see her husband one last time, as soon as she could. But by the time she learned of his death, the undertakers had taken his body to the mortuary. She spent the next few days trying to get permission to see him. However, she did not get to see him until Thursday 23 June when she saw him in the chapel of rest. By then, the post mortem had taken place and the fact that she could see the marks of the procedure on her husband added significantly to her grief.
34. The governor, who was the prison's family liaison officer, visited the man's wife at her brother's home on Wednesday 22 June and returned her husband's possessions to her. When she saw the bag that his things were in, she was upset because it was not his bag. The governor explained to her that the bag had been supplied by the prison. Staff at Kirkham explained to my investigator that, when a prisoner does not have a bag or holdall, they will provide one and this was what had happened with the man's belongings. Later, when the man's wife checked, she realised that some items were missing. She contacted the prison to tell them this and was asked to send a list of what was missing. She did this and the remaining items were posted to her, but it was disappointing that she did not receive all her husband's property together.
35. She told my investigator and FLO that she was not offered the opportunity to visit the prison and see her husband's room there. However, prison managers told my investigator that a governor did invite her to visit the prison in a telephone conversation with her. I cannot comment on the differing accounts. However, it is advisable that, in future, such invitations are repeated in a letter to avoid any confusion.
36. When asked by my Family Liaison Officer about funeral expenses, the man's wife said that the prison had not offered her any assistance. However, when the FLO informed the Governor of the outstanding total, he ensured that the prison dealt with the matter.

The Governor should amend his contingency plans to ensure that important information given verbally to next of kin is repeated in a letter. The letter should also contain information about the support available, including the offer of financial assistance for funeral expenses.

Issues considered during the investigation

The man's use of the gym

37. The man had a full gym induction shortly after arriving at Kirkham. He signed the Action Plan indicating that the contents had been explained to him and that he understood them. In his case, the plan stated that gym activities were excluded because of the health issues he had listed on the PAR Q. Kirkham is an open prison and prisoners are afforded as much self-determination as is possible within the prison system. The man's responses on the PAR Q show that he saw exercise as a way to keep himself fit and healthy, and it would seem that was his aim in playing badminton. Therefore, although he had been advised not to, his use of the gym was his own choice.

The location of the defibrillator

38. At present, Kirkham has one defibrillator. When the healthcare centre is open it is located there. When healthcare is closed, it is moved to the communications office. On 19 June, when The PEO called the communications centre to request a blue light ambulance and a defibrillator, a senior officer was in the centre. He immediately took the defibrillator and ran with it to the gym, arriving there within a minute or two of The PEO's call. The treatment the man received was not impeded by the absence of a machine in the gym. However, the local PCT is currently considering buying a second machine for the prison. I welcome this proposal.

Contact with the man's wife

39. Breaking the news of an unexpected death in custody is both sensitive and demanding. The way in which it is carried out may well colour the family's whole relationship with the Prison Service. The two main objectives should be to break the news speedily and to do so in a way that emphasises the Prison Service's accountability and commitment to the family as members of the public that the Service serves. I appreciate that speed and personal involvement of the Prison Service may sometimes be in conflict.
40. In this case, the managers' wish to break the news to the man's wife with as little delay as possible was commendable. And, given the distance involved, the decision to use the local police in her town was understandable. However, it still took until 11:00pm for police to arrive at her mother's home, some five hours after her husband's death. The place and manner in which the officers delivered the news was also far from ideal. The fact the officers could supply only the most minimal information about what had happened added to the man's wife's distress. She was also upset that the news of her husband's death was broken to her by police officers.

41. The man's death was completely unexpected and his wife's immediate, overriding concern was to see him one final time. In spite of numerous telephone calls over four days she did not get to see him until he was in the chapel of rest. By then, the post mortem had taken place and she told my staff that she could see the marks of the procedure on her husband, and that this had been really upsetting. It would have been helpful for her to have been able to see her husband much sooner after his death.

Recommendations

I am impressed by the prompt and professional actions of the PEO and recommend that the Governor formally commends him.

The Governor should amend his contingency plans to ensure that important information given verbally to next of kin is repeated in a letter. The letter should also contain information about the support available, including the offer of financial assistance for funeral expenses.