

**Circumstances surrounding the death of a prisoner at HMP
Standford Hill**

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

March 2008

This is the report of an investigation into the circumstances surrounding the death of a prisoner at HMP Standford Hill. The man collapsed in his cell and was discovered during the evening roll check. Prison staff and a prisoner trained in first aid attempted to revive him, but without success. Paramedics arrived and pronounced him dead.

The man was 64 years old. I would like to offer my sincere condolences to his family and friends for their loss.

One of my investiagtors conducted the investigation on my behalf. In addition, Eastern and Coastal Kent Primary Care Trust conducted a clinical review into the man's healthcare whilst in custody.

I would like to thank the Governor of Standford Hill, and his staff for their co-operation and assistance with the investigation. I am particularly grateful to the prison liaison who has been immensely helpful to the investigator in providing all the necessary paperwork. She also acted as the prison's family liaison officer, and I understand the assistance she has given to the man's wife has been greatly appreciated.

He had a history of heart problems and had suffered a heart attack in 1992. This was followed by a four-way heart bypass operation in 1993. Medical evidence suggests that he had also suffered from hypertension. The post mortem indicates that the man died from ischaemic heart disease and the clinical review concludes that nothing could have been done to prevent his death.

I commend the actions of staff when they found the man, and the subsequent liaison with his wife. However, I have made a recommendation surrounding the protocol for immediate contact with prisoners' families in these sad circumstances. The Governor and senior colleagues will also wish to keep under review the circumstances under which prisoners are asked to provide first aid and other assistance to their fellows.

Stephen Shaw CBE
Prisons and Probation Ombudsman

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CONTENTS

Summary	4
The investigation process	5
HMP Standford Hill	6
Key findings	7
Issues	10
Clinical review	12
Recommendations and good practice	13

SUMMARY

The man was sentenced to nine months imprisonment in May 2007. This was his first time in custody. On his arrival at HMP Belmarsh, he had a medical health screening in which it was recorded that he had suffered a myocardial infarction (heart attack) in 1993 and had undergone a four-way heart bypass operation in 1994. Healthcare staff also noted that the man had recently started smoking again after having abstained from the habit for a while.

All sentenced prisoners are allocated a security category, taking account of their offence and previous offending behaviour, so that they can be allocated to suitable establishments. The man was given the lowest security category (category D) and was therefore considered suitable for open conditions. Accordingly, he transferred to HMP Standford Hill on the Isle of Sheppey. On his arrival at Standford Hill, members of the healthcare team screened him again. They noted his previous chest problems and referred him for weekly blood pressure checks to monitor his hypertension. It was noted that he had previously self-harmed by taking overdoses of drugs, but he confirmed that he had no such thoughts at that time.

Given the short time that he was at Standford Hill, he had little time to become involved fully with the regime or be allocated work. However, he had undergone a full induction programme and indicated a desire to attend education and learn more about Information Technology (IT).

The man was visited by his wife during the weekend. At 8.40pm that evening, an Officer was on A wing conducting a roll check. When he arrived at cell 19, he found that he was unable to open the door owing to an obstruction. He alerted the Senior Officer to the situation. The SO managed to gain access to the cell and found the man lying on his back on the cell floor. With the assistance of another prisoner, the SO administered Cardio Pulmonary Resuscitation (CPR) and efforts to revive the man continued until the paramedics arrived. The paramedics declared him dead at 9.28pm.

After the man's death, The Governor ensured that the staff and prisoners involved were supported. Given the distance from the family home and the time of day, the prison asked local police to notify the man's wife of her husband's death. I am satisfied that staff took appropriate steps when he was discovered. However, it is unfortunate that, in spite of the late hour, his wife did not have access to anyone at the prison who could answer her immediate questions. I have therefore recommended that the prison protocols be revised to ensure that there are specific criteria for deciding who should communicate news of a death, and that a named contact is available to the family even if the death takes place late at night.

THE INVESTIGATION PROCESS

1. The investigation was opened at HMP Standford Hill by my investigator. The prison issued notices to staff and prisoners informing them of the investigation and inviting anyone who had relevant information to come forward. No responses were received.
2. My investigator visited the prison on 12 July. He met the Deputy Governor, and was shown the different areas of the prison including the residential area where the man had been located. During the investigation, my investigator was in regular contact with the Deputy Governor to clarify various matters and obtain further information.
3. One of my Family Liaison Officers (FLOs), contacted the man's wife to explain the role of the Ombudsman and discuss how any concerns about her husband's time in custody would be addressed during the investigation. The FLO offered to visit but the man's wife considered it unnecessary. She said she was very pleased with the way she had been dealt with by the prison.
4. My Investigator also contacted the individual who had been a prisoner at Standford Hill at the time of the man's death and had assisted in administering first aid to him. He has since been released from custody and I am grateful for his agreement to contribute to this investigation.
5. HM Coroner provided a copy of the post mortem report in which the cause of the man's death is given as ischaemic heart disease.

HMP STANDFORD HILL

6. Formerly known as HMP Eastchurch, HMP Stanford Hill is a category D male open prison on the Isle of Sheppey. Along with Swaleside and Elmley prisons, it forms part of what is known as the Sheppey cluster. The three prisons each retain their separate identity and are headed by a governor, but a Chief Executive responsible for major strategic and financial decisions under a Service Level Agreement manages the cluster.
7. Stanford Hill was first used as a prison in 1950 and the current accommodation was built in 1986. Over recent years, the prison has regenerated former staff quarters for use as classrooms but there are parts of the prison that are in desperate need of repair. This was highlighted in the most recent report by HM Chief Inspector of Prisons, Ms Anne Owers, who also said of the prison:

“At a time when open prisons are under considerable pressure managers and staff at Stanford Hill are to be congratulated for responding effectively to the challenges facing them, both in terms of their changing population and changes in the way that they and other prisons on the Isle of Sheppey are managed. There are a number of areas of improvement, not least the prison’s physical fabric, but this inspection demonstrated that Stanford Hill has a number of strengths to build on.”

8. The East Kent and Coastal Primary Care Trust provides healthcare at the prison. The healthcare centre is open daily and provides prisoners with access to other services such as the dentist, chiropodist and optician. Prisoners can apply to see visiting specialists and are able to visit the centre and request an appointment for all other matters. As with other areas of the prison, the healthcare centre would benefit from modernisation. In her recent inspection report, HM Chief Inspector recommended that priority be given to a new purpose built healthcare centre.
9. The Independent Monitoring Board (IMB) at Stanford Hill published an annual report in 2006 in which they said:

“The standard of cleanliness is on the whole good, though occasionally Board members have had to bring problems to staff notice.”

“The interaction between staff and prisoners, on the whole, continues to be excellent.”

“The Health Centre is visited frequently by the Board. The centre is in an aged pre-fabricated building where there is insufficient space to store medical materials. In the long term consideration needs to be given to relocating the facility.”

KEY FINDINGS

Events leading up to the man's death

10. He was convicted of theft and sentenced to nine months imprisonment. This was the first time that he had offended and consequently his first time in prison.
11. Following his conviction, the man was taken to HMP Belmarsh to begin his sentence. On reception, the healthcare team carried out a screening (a process to assess the health needs of individual prisoners on their arrival into custody, and treat or refer them as necessary). During the screening, the man reported that he had suffered from serious health problems for a number of years and had undergone a four-way heart bypass operation. He was also hypertensive (had high blood pressure) for which he was receiving medication and was awaiting a follow-up appointment at his local hospital.
12. He was located in a residential wing at Belmarsh and began to settle into the regime. As a newly sentenced prisoner, he was allocated a security category. (This is the system used by the Prison Service to allocate prisoners to suitable prisons based on the risk they pose to the public.) As he had no previous convictions and had not been convicted of a violent offence, he was considered to be low risk to the public and was classified as category D. This categorisation would enable him to be transferred to a prison with minimal perimeter security and be allocated work or training courses in the local community.
13. He was transferred to Standford Hill prison on the Isle of Sheppey. On arrival, he was again seen by healthcare staff. They reviewed his previous notes from Belmarsh referring to his chest problems and ongoing hypertension. He was told that he should attend for weekly blood pressure checks to monitor his hypertension.
14. The reception screen also addresses issues such as feelings of self-harm and, although he had previously taken overdoses and was subject to six-monthly psychiatric reviews, he stated that he had no feelings or thoughts of harming himself.
15. Apart from visiting healthcare for his regular blood pressure checks, the man had no other contact with the healthcare team at Standford Hill. The clinical reviewer, found nothing to indicate any deterioration in the man's clinical condition.
16. He went through the induction process which included, amongst other things, a gymnasium assessment. In view of his chest problems, it was recommended for him to take part in remedial swimming. It seems that he did not have the chance to use this facility before his death. During induction, he was also allocated employment and it is recorded that he had expressed an interest in education and taking a course in IT (Information Technology).

17. On the weekend of his death, his wife visited him. Following the visit, he returned to the wing and spent time in his room before collecting his evening meal. (As at other open prisons, the prisoners at Standford Hill have keys to their own rooms/cells as a means of giving them more responsibility.)
18. At 8.40pm, an Officer was in the process of counting the prisoners on A1 landing. On his arrival at the man's cell (A1-19), he attempted to gain access but could not do so because of an obstruction. He called the SO who was also on the landing, to assist him. The SO gained access to the cell and discovered that the obstruction had been caused as a result of the man having collapsed. He was lying with his feet up against the door. The SO could find no obvious signs of life but immediately started to administer Cardio Pulmonary Resuscitation (CPR).
19. Other members of staff were alerted to the situation and the emergency services were called at 8.45pm. When another SO heard that a prisoner had been found collapsed on A wing, he immediately collected one of the prisoners on another wing who he knew to be trained in first aid, to assist the SO in his attempts at resuscitation. The prisoner was trained in first aid to instructor level and, along with members of the gymnasium staff at Standford Hill, had been involved in training both staff and prisoners in first aid. The SO who collected him was aware of his qualifications. He told my investigator that, when he informed the prisoner of the situation, he was more than happy to assist.
20. The SO and the prisoner moved the man onto the landing to give more room and continued to administer first aid. Whilst they were doing so, other members of staff arranged a screen around them for privacy and to preserve the man's dignity.
21. At 8.58pm, a crew from Kent Ambulance Service arrived and took control of the resuscitation attempt. Both the SO and the prisoner continued to rotate the CPR under the direction of the ambulance crew. At 9.28pm, the man was confirmed dead.

Events following the man's death

22. The Governor arrived at A wing shortly after the man had been pronounced dead and spoke to both the SO and the prisoner who had administered CPR. All other staff involved were spoken to before going off duty, and staff confirmed that the prisoner who had helped was feeling all right before he returned to his wing.
23. The prison contacted Police in the man's local area at 9.55pm and asked them to inform his wife of his death. In these circumstances, it is usual for the prison to send a member of staff to notify the next of kin. However, the decision to use the local police was based on the distance involved and the time of day. At 1.30am, the local Police confirmed to the control room at Standford Hill that the man's wife had been notified and would be making contact in due course.

24. The man's wife telephoned the prison at 1.45am, and asked about the process that she should follow. Unfortunately, there were no senior managers available to advise her and she was told to call again at around 8.00am. During the call to the control room, she said she had visited her husband on the day of his death, and that she did not think he looked very well.

ISSUES

First Aid

25. My investigator found that Standford Hill was short of staff trained in first aid. The Deputy Governor explained that officers had moved within the Sheppey cluster and this had reduced the number of trained staff available. However, these issues have since been addressed and, as of October 2007, there were 22 first aid trained staff, of whom two were first responders with the retained Fire Service. The programme of first aid training at Standford Hill continues and all staff are going to attend a heart start accredited CPR course.
26. The use of a prisoner, to assist the SO in administering CPR highlights the community ethos that Standford Hill tries to foster amongst both staff and prisoners. Prisoners who have completed first aid courses sometimes assist staff during medical emergencies. Many prisoners, are trained to a very high standard and intend to use their skills on release from custody.
27. The duty of care remains with the Prison Service, and there are evident dangers in relying upon fellow prisoners to provide first aid and CPR. However, the prison welcomes the involvement of prisoners, believing that the dangers are outweighed by the benefits both in the quality of first aid assistance that can be provided and the wider message that is conveyed. In the context of a jail like Standford Hill, I can understand that approach entirely. However, the Governor, Chief Executive and Area Manager may wish to discuss the implications and keep the matter under review.

I commend the Senior Officer and fellow prisoner for their efforts in trying to resuscitate the man. The Governor will wish to share my views both with the SO and in a letter the individual who has since been released from custody.

Contact with the family

28. It is regrettable that, when the man's wife contacted the prison after being notified of her husband's death by the police, she was unable to speak to anyone. Instead she was asked to call later the next morning. Anyone who has just suffered an unexpected bereavement, will have immediate questions and concerns.
29. Local Police were asked to break the news rather than staff from a prison closer to the man's home address. Although the police broke the news sensitively, staff from another prison might have been in a better position to obtain answers to some of his wives initial questions. Prison Service policy is that, wherever possible, news of a death in custody should be delivered by the prison concerned or by staff from a prison closer to the prisoner's home. While I appreciate the difficulties for relatively small prisons when deaths occur in the evening or at night, I believe the Governor of Standford Hill should consider if there are alternative arrangements he could put in place.

The Governor should revise the local protocols to ensure that there is an identified senior manager as the point of contact in instances where another prison or the police are asked to deliver news of a prisoner's death. The control room officer should be in a position to pass the contact details of the manager to the next of kin if they contact the prison, regardless of the time of day. The Governor should also specify in these protocols the criteria for deciding who should inform the next of kin.

30. The Deputy Governor took on the role of the prison's Family Liaison Officer (FLO). I judge that she handled her responsibilities very professionally, and I understand the man's wife greatly appreciated her assistance. In spite of this, my investigator found that there was a need for strengthening of the FLO role at Standford Hill. This was communicated to the Governor during the course of the investigation and has since been addressed by appointing the Head and Deputy Head of Residence as FLOs. The Deputy Governor will remain as a reserve and provide experienced support.

The Deputy Governor should be recognised for the professional way in which she carried out the Family Liaison role.

CLINICAL REVIEW

31. Eastern and Coastal Kent Primary Care Trust conducted the clinical review of the man's medical care in prison custody.
32. A copy of the full review was made available to interested parties. However, I reproduce conclusions here as follows:

“The man who died at the age of 64 years had pre-existing and severe heart disease prior to his admission into the custodial environment. There was no apparent reason to believe that his death was imminent although it could be postulated that the stress of imprisonment triggered off a final and fatal episode.

“Apart from the above, there is nothing in my opinion that the prison health services could have done to prevent the man's sudden death.”

RECOMMENDATIONS AND GOOD PRACTICE

I commend the Senior Officer and fellow prisoner for their efforts in trying to resuscitate the man. The Governor will wish to share my views both with the SO and in a letter to the individual who has since been released from custody.

The Prison Service accepted this recommendation and responded:

The SO will be recognised via the staff recognition committee for this. Letter to be sent to the ex-prisoner from the Governor

The Governor should revise the local protocols to ensure that there is an identified senior manager as the point of contact in instances where another prison or the police are asked to deliver news of a prisoner's death. The control room officer should be in a position to pass the contact details of the manager to the next of kin if they contact the prison, regardless of the time of day. The Governor should also specify in these protocols the criteria for deciding who should inform the next of kin.

The Prison Service accepted this recommendation and responded:

The contingency plans are currently being up dated & will read.

- *The Governor should deploy a **FLO** either from the host establishment or from Cluster/Area resources.*
- *The **FLO** should have a nominated **Deputy** to act in their absence.*

These roles must remain separate from role of Inquest Liaison Officer.

If the FLO is unavailable, the responsibility for maintaining contact with the next of kin should fall to the Duty Governor followed by the Governing Governor.

A Notice to Staff (NTS) will be issued highlighting these changes.

Night Orderly Officer (NOO) and Communications Officer instructions will be amended accordingly.

The Deputy Governor should be recognised for the professional way in which she carried out the Family Liaison role.

The Prison Service accepted this recommendation and responded:

Letter to be sent from the Governor to Deputy Governor as recognition of her work as FLO

