Investigation into the circumstances surrounding the death of a man at HMP Hewell in August 2010

Report by the Prisons and Probation Ombudsman for England and Wales

December 2011

This is the report of an investigation into the circumstances surrounding the death of a man, a prisoner at HMP Hewell. He died in August 2010, aged 45 years old. I would like to offer my sincere sympathy and condolences to his family for their loss.

The investigation was carried out on behalf of the Ombudsman by an investigator. I would like to apologise for the time taken to issue this draft report and any additional distress this may have caused. I would like to thank the Governor of Hewell and his staff for their co-operation during the course of my enquiries. Thanks in particular to the liaison officer who arranged and co-ordinated all the interviews and liaison.

The local Primary Care Trust (PCT) was commissioned to conduct a clinical review into the standard of healthcare the man received whilst in custody at HMP Hewell. A clinical reviewer was appointed.

The man had been in and out of custody at HMP Hewell for various minor offences. He had learning difficulties and had suffered from a stroke in 2007 that had affected his right side and caused him to walk with a limp. He was considered to be a vulnerable man, who could often be forgetful but who could also, on occasion, act aggressively.

He had some interactions with healthcare at the prison and had been provided with painkillers on a number of occasions. He saw a doctor once after complaining of pains in his chest but later described these as being in his side. There was no indication that he was suffering from any serious health problems.

On 18 August, the man's cell was unlocked at approximately 8.05am by an officer. The officer was unable to see him, so went inside his cell. He found him on the floor next to the toilet. He attempted to get a response from him, although it was evident to him that he had died. A nurse attended and confirmed that he had died.

The coroner recorded the man's death as cardiomegaly in association with prior cerebral infarction – an enlarged heart associated with his previous stroke.

The arrangements for checking prisoners at the time of the man's death were not clear. I make three recommendations in my report regarding the Night Operating procedures, medical records and requesting a prisoner's medical records.

This version of my report, published on my website, has been amended to remove the names of the man who died and those of staff and prisoners involved in my investigation.

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Prisons and Probation Ombudsman **December 2011**

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SUMMARY

1. The man was born in September 1965. He died while in the custody of HMP Hewell in August 2010, aged 45 years old. He had learning difficulties and had suffered from a stroke in 2007, which had left him with reduced mobility on his right side and caused him to walk with a noticeable limp. Due to drug use in previous years, he had contracted Hepatitis C. His family described him as a vulnerable individual, who was easily led and was often very forgetful.

2. The man was remanded into HMP Hewell on 26 July 2010, charged with assaulting a police officer. This was not his first time at Hewell, he had served a few short sentences a year previously for minor offences.

3. A care plan was enclosed in his prisoner escort record that accompanied him from the police station and Magistrates Court. The care plan made by a police officer outlined issues regarding drug use and accommodation on release. He had said that he had no suicide or self harm issues. The police officer recorded that he was to have routine observations and there was no requirement for medical intervention.

4. During his first reception health screen on arrival at Hewell, a nurse thought that he presented as intoxicated, although he denied drinking alcohol in the previous week. Officers knew him well from his previous stays at Hewell and told the nurse that he often presented in a "strange manner". He declined to see the doctor as he thought he was only there for the night. He said he did not have any disabilities, but could not manage stairs due to his limp. The nurse advised him that he could contact healthcare at any time, should he feel the need. He went through the cell sharing risk assessment process, and was allocated a single cell on a normal wing. He said that he had used drugs in the past and described himself as a person who could become angry and frustrated easily.

5. In reception, the man signed a Disability Questionnaire. This is to ascertain any special needs a prisoner may have whilst in custody. However, he said he did not have any disabilities he wished to disclose and signed the form to that effect.

6. Staff found him to be a vulnerable person who found it hard to grasp prison life. He was said to have difficulty engaging with other prisoners and would often become argumentative and awkward towards staff. He received two cautions for negative behavioural conduct in one day.

7. On 2, 5 and 11 August, the man was provided with paracetamol. The reason for its issue is not clear from his medical record. At 12.00pm on 11 August, healthcare received a call that he was suffering from chest pain. On examination he said he had a sharp pain on his left side which he said he had been suffering from on and off for the past week. His blood pressure and pulse were stable and a routine appointment was made for him to see a doctor.

8. A doctor examined the man on 16 August. It is noted in his medical record that he said the pain was on his right side and had been present for two weeks, was getting worse and nothing was easing it. He had reduced movement in his right lower chest, although his chest was clear and he was leaning to the left and looked in pain on movement. The doctor prescribed ibuprofen and advised him to move about gently and drink plenty of fluids.

9. During the morning and evening of 17 August, a nurse gave him two more doses of paracetamol. He was then locked in his cell for the night at approximately 8.00pm. At approximately 5.30am the next day an officer called in the roll check (this is a check which is conducted to ensure all prisoners are present) although he said he did not conduct a physical check on him at the time.

10. An officer unlocked the man's cell at approximately 8.05am. He said he could not see him and so went inside. He found him on the floor next to the toilet. He attempted to get a response from him although it was apparent that he was dead. He made a code blue call (which means urgent assistance is required as a prisoner is not breathing) over his radio for healthcare to attend. A nurse arrived and confirmed that he had died. Paramedics were called to certify his death as there was not a doctor on duty at the time.

11. I make three recommendations in this report. One relates to the Night Operating Procedures, regarding roll checks. I believe there is a need to clarify and update the instructions to staff. The other two recommendations are directed to the Head of Healthcare and involve the standard of record keeping in medical records and the need to request a prisoner's previous medical records from the community.

THE INVESTIGATION PROCESS

12. The investigation was opened by one of the Ombudsman's investigators. He met with senior prison managers and requested copies of prison documentation relating to the man, which was not ready at the time. There was a significant delay in receiving this documentation, which consequently impacted the investigation process and the timeliness of producing this report.

13. Notices of the investigation were issued to staff and prisoners, inviting those who wished to provide information regarding the man's death to make themselves known to the investigator. No-one came forward with regard to the notices. The investigator visited the prison on 4 November 2010 and 8 February 2011 to interview staff.

14. My investigator wrote to the Chief Executive of the local Primary Care Trust (PCT) to commission a review of the man's clinical care whilst he was at Hewell. The PCT asked a clinical reviewer to carry out the review. The clinical reviewer received a copy of the relevant medical documents upon which he based his findings.

15. My investigator contacted HM Coroner for Worcester to inform him of the nature and scope of the investigation. Upon completion, a copy of my report will be sent to the Coroner to assist his enquiries into the man's death.

16. West Mercia Police conducted an investigation into the circumstances surrounding the man's death, but found there were no suspicious circumstances.

17. My investigator provided feedback to the liaison officer at Hewell during the investigation as the Governor was unavailable, highlighting preliminary findings and any issues that had become apparent.

18. One of the Ombudsman's family liaison officers contacted the man's family at the beginning of the investigation. She informed them of the investigation and offered them the opportunity to raise any questions or concerns they would like addressed during the investigation. The family raised the following issues:

    - His physical and mental health issues would have been apparent to anyone meeting him for the first time. They are concerned that he was located in a cell on a normal wing following his initial health screening at reception, as during his previous time at Hewell he was on a special wing. The family are concerned that he was not located somewhere more suitable on this occasion.

    - The family felt that he would not have been able to give a full account of his medical needs and that the prison would have realised this on meeting him. They would like to know if the prison sought his medical records from his General Practitioner (GP) in the community.

- When the Governor visited to break the news of his death he told the family that he was found sleeping peacefully in his bed and his death was believed to be by natural causes. They later saw an e-mail which was sent to INQUEST which said he had died from a heart attack and he was found on the toilet floor. (INQUEST is a charity who provides a specialist advice service about deaths in custody.) The family are concerned that they were told incorrect information by the Governor and that it was reported to be a heart attack even though the cause of death was yet to be determined.

- He would complain daily of pains in his chest and down his right hand side. The family are concerned that the medication given to him was not suitable given he had heart problems, had had a stroke and had hepatitis C. They are also concerned that someone with mental health issues and who was vulnerable like the man had this medication in his possession.

- The family described how he would have seizures every other day over the last few months which were obvious to anyone who was with him as his body would go into spasm. They wondered whether these were picked up by the prison.

- The prison's Family Liaison Officer told the family that a condolence card had been written by the other prisoners since his death. They had not received this.

19. Since the Ombudsman was given responsibility for investigating all deaths in custody for England and Wales in April 2004, there have been eleven deaths at Hewell, five of which were due to natural causes. There are no similarities in relation to this investigation and any of the previous deaths at Hewell.

20. The prison responded to the draft report on 1 November 2011. They identified one factual inaccuracy in paragraph 26 which refers to the number of house blocks at Hewell. They also partially accepted one recommendation and accepted the other two. This is explained on the Recommendations page of this report.

21. The family were given the opportunity to comment on the draft report. They spoke to another Family Liaison Officer who took over from the first Family Liaison Officer on 14 December and confirmed they had no comment to make on the report.

HMP HEWELL

22. HMP Hewell was created on 24 June 2008 by merging three separate prisons which were located on adjacent sites (HMP Blakenhurst, HMP Brockhill and HMP Hewell Grange). Hewell primarily serves the West Midlands, Worcestershire and Warwickshire areas.

23. The new prison accommodates different categories of prisoners. House blocks are divided into wings. House blocks one to six form the Category B prison and holds prisoners remanded by the courts, those awaiting sentence and convicted prisoners (including those sentenced to life imprisonment) and those awaiting transfer to training prisons. Wherever possible, prisoners are allocated to a house block according to their categorisation.

24. Healthcare is provided by the local Primary Care Trust. The unit has 24 hour nursing staff, with in-patient care situated on the lower floor of the unit (known as lower medical). All in-patients are encouraged to associate out of their cells, including eating in a communal dining area. There is a varied timetable of activities with nursing staff supporting patients to actively socialise together. A weekly multi-disciplinary meeting is held to discuss individual cases (both those who are physically and mentally ill).

HM Chief Inspector of Prisons report (HMCIP)

25. The first inspection of HMP Hewell by the HM Chief Inspector of Prisons was in November 2009. In regards to the reception and induction areas of the prison, the report found:

> "The reception area for house blocks one to six was busy. Revised first night procedures on house blocks one to six were not yet embedded. Insiders across the prison gave new arrivals advice and support. (Insiders are prisoners who are trained to speak and listen to other prisoners, if they have any problems or just need to talk to somebody.) The induction programme on house blocks one to six had input from a relevant range of departments. Short-term resettlement plans raised during induction were often incomplete.
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> "The house blocks one to six induction was a three-day rolling programme, which began the day after arrival with prisoners having the opportunity to meet staff from departments across the prison, including the counselling, assessment, referral, advice and throughcare service (CARATs), chaplaincy and healthcare, and a follow-up interview with Offender Management Unit staff. The area was busy but house block staff and Offender Management Unit staff managed the process to ensure prisoners were seen by all relevant agencies.
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> "During these interviews, staff were supposed to complete the appropriate section of the prisoner's short-term resettlement plan to document his identified needs and any action taken. Although onward referrals were

made from these interviews, this was not indicated in the plans we viewed, many of which were incomplete."

Disability (from HMCIP report)

26. Disability liaison officers, or deputies, are based on all wings and, although there is a comprehensive policy, the role of these staff is unclear. There are no forums for prisoners with disabilities and no identified prisoner representatives. All prisoners are asked to complete a disability questionnaire during induction, which is comprehensive and covers most key issues. House block 6 has four single cells adjusted for prisoners with disabilities, with appropriate shower facilities on the wing, as well as a lift to different levels. Two further cells have been adapted in healthcare, and other inpatient cells allowed reasonable wheelchair access. Although there is no formal policy on helpers for prisoners with disabilities, other prisoners and staff often offer informal support. The Inspectorate report recommends that:

> "A quality assurance scheme should be introduced to ensure that the individual needs of prisoners with disabilities are met".

Tackling Antisocial Behaviour (from HMCIP report)

27. The tackling antisocial behaviour (TAB) system was embedded and well used. The quality of TAB documents was good but monitoring entries could be improved. Bullying was an issue on house blocks one to six but staff were robust in tackling it. The quality of investigations was good and the violence reduction coordinator followed up each incident.

Person Escort Record (PER)

28. The police, courts, escort and prison services have an agreed procedure for sharing information about prisoners as they are moved between their establishments. It is essential that, when a prisoner is moved from a police station, court or prison to court, prison, hospital or other destination, those responsible for the prisoner are made aware of any risks or vulnerabilities. In particular it is essential that known risks of escape, assault, suicide/self harm or harassment are communicated to others into whose custody the prisoner is passed; to protect prisoners, staff and the public. It is also essential that any new risks that develop during a movement are recorded and flagged up for others. The PER is the key vehicle for ensuring that information about the risks posed by prisoners on external movement from prisons or transferred within the criminal justice system is always available to those responsible for their custody.

Reception

29. When prisoners arrive at the prison, all their paperwork is checked before they are taken off the escort vehicle. Staff check the warrant to ensure that the correct prisoners are in custody, and then prepare the necessary records. The prisoner is taken from the vehicle and booked in by the senior officer on

the front reception desk. Personal and offence details are taken, along with any known concerns. Reception staff do not have access to any previous custodial history at this time.

30. All prisoners see the first night in prison officer, reception officers, and the nurse on duty. During this process, staff obtain their address and next of kin details. Prisoners can choose who to name as their next of kin and do not necessarily identify the person who is their legal next of kin. They are normally entitled to make a free telephone call from reception so that they can inform someone of their whereabouts.

31. New prisoners are allocated a prisoner number, irrespective of whether they have been in prison before. They are strip searched, their property is logged, and they are health screened, before being placed in a holding cell, ready for staff to take them to a house block.

Cell sharing risk assessment (CSRA)

32. In order to make sure that unsuitable prisoners do not share cells, a cell sharing risk assessment is completed by reception staff when a prisoner first arrives at the prison.

Roll check

33. The roll check is the physical count of the number of prisoners on each wing within a prison. Roll checks occur at specified times during the day, and staff must sign that the roll is correct. Hewell's local procedures state that roll checks should be carried out at 6.00am, 12.30pm, 5.30pm and 8.00pm.

Independent Monitoring Board (IMB)

34. Each prison in England and Wales has an Independent Monitoring Board responsible for monitoring day-to-day life in the prison and to ensure that proper standards of care and decency are maintained. The latest report published by the IMB for December 2008 to November 2009 stated that:

> "This is the first Annual Report since the formation of HMP Hewell in June 2008 and covers the period 1st December 2008 - 30th November 2009. In its first, short, (25th June 2008 – 30th November 2009) report, the Board noted that many policies and protocols could only be produced once the prison had been opened. The Governor has an open approach and her style of management not only identifies problems but ensures they are dealt with. The path of progression throughout the prison - *One prison, One vision* - is encouraging as is the continued consolidation of policies and protocols.
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> "The Board understands there is still a need for Prison Officers to attend diversity training. A reason for this has been the difficulty in releasing staff from normal duties to attend, at a time when there was also training for new programmes. The Board recognises there is also a need for staff

from other agencies (e.g. Healthcare and Probation) to receive this training and will continue to monitor the take-up statistics."

KEY EVENTS

35. In February 2009, the man was remanded from court into Hewell. In his Person's Escort Record (PER) form, it was noted that he had a mental health condition and had needed an appropriate adult present for his interview. The PER form is used to log any relevant information about the individual so that staff at different establishments are aware of any concerns.

36. On 22 February the man was assaulted by another prisoner. He was moved to another wing and a tackling antisocial behaviour (TAB) support plan was opened. These documents are used to support victims of bullying and to ensure their safety is maintained. He was made aware of Listeners (other prisoners who have been trained by the Samaritans to provide support to those who feel vulnerable or at risk) available on the wing and was examined by healthcare staff. It was recorded within his TAB plan that his peers were mocking him, although he seemed unaware of this. Staff dealt with those responsible, however they said it was difficult to keep an eye on him all the time without him becoming paranoid and aggressive. Staff felt that he would be better located in lower medical (in healthcare) for his own safety and the move was facilitated. He was prescribed medication (no record of what his medication was) to calm his behaviour and the support plan was closed on 1 March.

37. During his post sentence interview on 5 March, he said that he had had learning difficulties since childhood and was under the care of the local authority. He was said to be very calm at the time of the interview but staff were aware that he could become very volatile.

38. The man went back into Hewell for a short period in April. During his induction he stated that he did not have a disability. It was recorded within his on-going wing record that he had mental health problems and suffered from vertigo. There were no significant events during this time at Hewell.

39. In May, the man spent another brief period in Hewell. In his cell sharing risk assessment (CSRA) form it was recorded that he appeared confused and forgetful and that he had no previous drug use. An officer conducted an allocation assessment. In the assessment one of the questions asks if the individual has any needs relating to disability. The officer wrote that he had a problem with his legs. Staff recorded in his wing on-going record that he was known to staff and presented no real issues. He expressed an interest in education, however it was recorded that the assessment did not take place as he had mental health issues and learning difficulties.

40. The man was released on 22 May; however he was remanded back into Hewell a week later. During the induction process it was recorded that he had no special needs. His CSRA form showed that he was hard to manage, had poor hygiene and displayed anti-social behaviour. He was reported to be as likely to harm someone else as he was to be harmed by them, therefore he was allocated a single cell. On 13 May it was recorded that he threw a plate at a wing officer. This was his last time in custody in 2009.

41. The man was charged with assaulting a police officer and remanded into Hewell on 26 July 2010. A care plan was enclosed in his Person Escort Record (PER) form, which accompanied him from the police station to the Magistrates Court and then on to Hewell. The care plan stated that he had said he was a habitual cannabis user, but did not think it had made him suffer from any kind of psychosis. He had said that he had suffered from outbursts of violent behaviour throughout his life and as a result he was no longer welcome at his home address and had nowhere to live. The police had asked social services to intervene as accommodation in the past had been an issue due to his history of aggression and violence.

42. As this was not his first experience of being in custody at Hewell, staff knew him well. It was known that he had learning difficulties and was very forgetful, had suffered from a stroke in 2007 and that suffered from Hepatitis C, which he had contracted through drug abuse in previous years.

43. A nurse conducted a first reception health screen. She did not have access to the man's medical records from his previous periods at Hewell at this time. She noticed that he seemed intoxicated, although he said he had not drunk alcohol in the past week. Officers in reception told her that they knew him from previous stays at Hewell and that he often presented in a strange manner. He declined to see the doctor as he thought he was only going to be there for one night, although this was not the case. She recorded in his medical record that he presented as fit on observation and in physical appearance and was bright and chatty. He told her that he had no concerns for his physical health and that he had seen a doctor in the previous few months, however he could not remember what for. He had bruising to his left eye, which he claimed was done by the police when they arrested him.

44. A follow up appointment with a doctor (known as a second health screen) was not arranged and his medical records were not requested from his community doctor.

45. During his assessment for cell allocation, it was noted that there was information that indicated he was a high risk prisoner, which needed investigating through the review process. The CSRA form shows that there was insufficient evidence of a risk of harm to others and that he had shown no anti-social behaviour. He said that he had used drugs and described himself as the type of person who gets angry and frustrated easily. After consideration by staff, he was allocated a single cell on a normal residential wing.

46. During his first day, his induction paperwork indicated that he was not detoxing from drugs and was residing on a normal wing. He said that he did not have any disabilities, although he could not manage the stairs and had a limp. There were no staff concerns regarding his disability or health. The rest of the induction document is not filled out, suggesting he did not complete his induction. My investigator was unable to find any explanation for why this did not happen.

47. The man attended court on 27 July. He was refused bail and told to appear before the court via video link on 2 August.

48. On 28 July, the man attended a housing needs assessment. Contrary to his care plan from the police, he said that he had a discharge address with a family member and that he was not claiming housing benefit, which also contradicted information he had provided on reception.

49. A cell sharing risk minimisation plan meeting was held on 30 July. During the meeting it was noted that he had always been of single cell status, but that his original CSRA form could not be found. He remained at high risk of harm to others. It was noted that he had difficulty engaging with other prisoners and could be vulnerable. A review was scheduled to be held in one month's time.

50. A Senior Officer (SO) made a note in the man's wing record on 1 August. She wrote that he was known to staff as a regular visitor to Hewell. He struggled to grasp basic prison life, however he was capable of ordering meals and his canteen but sometimes "acted ignorant" which ended up causing disruption. He had not ordered his lunch time meal and became awkward, argumentative and used obscene words towards the SO. She tried to guide him out of the servery and told him that she would not tolerate being abused or sworn at. He then became very loud and threatening towards her. Four other officers assisted in returning him to his cell while he continued to abuse and swear at staff. He was taken back to his cell to calm down.

51. An officer went to talk to him later that afternoon. He explained that if he continued not doing as staff asked him to, then he would be moved to the Segregation Unit. He said he would apologise to the SO.

52. On 2 August, the man appeared at the magistrates' court via video link. He remained remanded into custody and his next court appearance was scheduled for 23 August.

53. The next day it is noted in the man's medical record that a nurse gave him paracetamol; however the reason it was given is not clear in his medical record. Another nurse gave him paracetamol again on 5 August. Again, his medical record does not show what is was given for, but it appears that he would often request a painkiller.

54. The man received two Incentives and Earned Privilege (IEP) scheme warnings on 10 August. Under the IEP scheme there are three regime levels: Basic, Standard and Enhanced. The level a prisoner is on will determine the number of privileges he or she may have access to. He was on standard level. The first warning was for smoking on the landing on two separate occasions during association on the afternoon of 9 August. The second warning was for misuse of his cell bell twice during lunchtime patrol state (misuse of a cell bell usually means using it for anything other than an emergency when the prison is in patrol state. Patrol state is when all prisoners are locked in their cell and a minimum amount of staff are on duty,

usually during the lunch time period.) When he was challenged he became verbally abusive to staff.

55. During the morning of 11 August, a nurse gave the man paracetamol. Once again it was not evident in his medical record as to the reason why. However at 12.00pm wing staff made a call to healthcare as he was suffering from chest pains. She went back to the wing to examine him. He told her that he had a sharp pain in his left side (not in his chest) and the pain had been coming and going over the last week. His blood pressure and pulse were stable, so she made him a routine appointment to see the doctor.

56. Officer A made an entry on the man's National Offender Management Information System (NOMIS) file (an electronic file which shows all information throughout custodial sentences) on 15 August. The officer recorded that he was becoming an increasingly difficult prisoner to manage on normal location. He was clearly bored in custody, however he would not engage in any activities and used excuses when others tried to encourage him to participate. This made it very difficult for staff to affect any positive change. He was manipulative towards staff and appeared very restless when in his cell.

57. A doctor examined the man on 16 August. He told her that he had a pain in his right side (as opposed to the pain he described in left side on 11 August) which had been present for two weeks, was getting worse and nothing was easing it. She could not feel his liver, his abdomen was soft, and there was no mass or spinal tenderness. She noted in his medical record that his chest was clear, but he had reduced movement in his right lower chest, he was leaning to the left and looked in pain on movement. She prescribed ibuprofen to have in his possession and advised him to move around gently and drink plenty of fluids.

58. A nurse gave him paracetamol in the morning and evening of 17 August**.** Again, there is no explanation noted in the medical record, but it seems likely it was in response to him saying he was experiencing some pain.

59. Prisoners are locked into the cells for the night at approximately 8.00pm according to the prison regime. Officer B was on night duty and he performed a roll check at the start of his shift. During the investigator's interview with him it became apparent that the procedures for when to conduct a roll check and what is required, are confusing. He said that he conducted a roll check when he came on duty, but not one before he left the prison at approximately 5.30am. He explained that he had received training from other members of staff of the same grade as him and that is what he had been told to do. (He said that since then the Night Operating Instructions regarding roll checks had been revised.) He said in his police statement that during the course of the night he checked three prisoners on Assessment, Care in Custody and Teamwork (ACCT) monitoring procedures, which are used to support prisoners at risk of self harming, and documented his observations in their files. One prisoner came onto the wing to use the crisis suite, which was the only movement on the wing during the night.

60. At approximately 5.30am on 18 August, the officer called in the roll count as he was confident that everyone was accounted for, although he had not conduct a physical check. This means that he confirmed with the control room in the prison that all prisoners were present. He said that the man did not call for attention at any time and no information was given to him or documented at handover from the day shift to suggest any special checks were to be made on him during the night.

61. At approximately 8.05am, Officer A unlocked the man's cell. He could not see him on unlocking the door and so he went inside. He discovered him lying on the floor by the toilet. He attempted to get a response from him and shook him. He did not respond and felt stiff to the touch, and the officer believed he had died. He called a code blue over the radio for healthcare to attend immediately. (A code blue alerts officers and healthcare staff to an emergency involving unresponsiveness and absence of breathing.)

62. A nurse responded to the code blue call immediately and on arrival on the wing was escorted to the cell by an officer. She said in her statement that on entering the cell, she saw the man lying on his right hand side, beside the toilet. The skin on his arms and on his right side was mottled, his skin felt very cold to touch, his arm was stiff. Two nursing Sisters arrived at the cell shortly afterwards with further equipment in response to the code blue call. The nurse said that no CPR attempts were made as rigor mortis had clearly set in. (Rigor mortis is where the body stiffens; it starts approximately three hours after death.)

63. An ambulance was called as there was no doctor on site to certify the man's death. The paramedics arrived at 8.50am. A doctor arrived at Hewell at 9.00am for duty. He was informed of the death and attended his cell. He recorded in the medical record that he had died and was last seen the previous evening during the "pill parade" (when prisoners are given their medication) when had appeared normal.

64. A hot de-brief (an opportunity to discuss what happened, to look at how the situation was managed and how staff felt) for staff involved in the man's care was held in the chapel at 12.15pm. No issues were raised.

65. All prisoners who were affected by the man's death or wished to speak to someone were given the opportunity to speak to staff, members of the Chaplaincy or Listeners. They also had access to the Samaritans telephone. All prisoners who were on an ACCT procedures were reviewed.

66. The Governor, prison chaplain and the prison's family liaison officer visited the man's family on 18 August at around 9.40am. They explained to his father what happened, who then rang his daughter to join them. The prison staff then explained the help and support available to the family and said that they would contribute towards the funeral expenses.

67. The man's funeral took place on 6 September. The prison asked to send flowers, but the family said that they would prefer a donation to be made to a children's charity.

68. On 10 September, the family liaison officer was told that the man's family had been told that he had died from a heart attack. This information had come from a member of INQUEST who had been told this by a member of staff from the National Offender Management Service (NOMS). The family were also concerned that the Governor had said that he had died in bed, as they now knew he was found dead on the floor of his cell, by the toilet. There had also been a mix up at the Funeral Directors, who understood that a closed coffin was required, but this was not the case. The Governor wrote to the family apologising for any distress or incorrect information he had passed on.

69. The prison's family liaison officer forwarded the condolence card from prisoners at Hewell to the man's family.

ISSUES

Timely and appropriate clinical care

70. The clinical reviewer stated that "The man clearly suffered a catastrophic event which was sudden, unexpected and unpredictable. On review of all the information provided I could find no evidence that the care he received in prison differed to the care he would have expected to receive in the community."

71. He makes three further comments in his clinical review. These relate to the prison's management of chronic diseases and long term conditions, the need to request community and secondary health care records when considered appropriate and necessary, and that there should be no barrier to people contacting healthcare with any concerns relating to health or medication issues. I agree with the points he raises and believe that the man's community medical records should have been requested. He presented strangely to staff and had an obvious physical disability, so it would have been prudent to have sought further information from his doctor.

The Head of Healthcare should ensure that a prisoner's medical records are obtained, particularly when there is an obvious history of illness, mental health issues or a disability.

72. The clinical reviewer also notes in his review that the man did not have a secondary health screen, which should be offered to all new prisoners. It may have been because he was known to staff at Hewell, or it may have been an oversight. Whichever, I believe a secondary health screen should have been carried out. I understand that this has now been addressed at the prison, so for that reason I make no formal recommendation here.

73. The clinical review also highlights the fact that the reasons for administering medication to the man were not recorded in the medical record, nor the reason for his requests. He makes no recommendation on this point. However I believe that clinical records should have recorded the reasons for administering the paracetamol to him.

74. With regard to the issue of paracetamol to the man, it appears from medical records that he was given two 500mg tablets when requested, to take as required. However, confusingly, the medical records state "take 1 or 2 4 times a day". It appears from the records, however, that he did not keep a great quantity of medication in his possession. If he were in the community he would have been free to take paracetamol over the counter without explaining why he needed them. However, it forms a pattern of behaviour which can give an indication of a medical problem.

The Head of Healthcare should ensure that the reason for administering medication to prisoners is recorded in the medical record.

75. When the man was found, staff did not attempt to resuscitate him. The clinical reviewer says that it was appropriate not to start CPR as it was obvious that he had died. He states "This is in accordance with guidelines to preserve dignity and reduce stress when death is obvious". Indeed, this is in accordance with Prison Service policy, where it is clear that there is evidence of rigor mortis.

Roll check

76. The procedures for conducting roll checks at Hewell at the time of the man's death were confusing. Certainly the member of staff who was on duty that night seemed to think that when he took over responsibility for approximately 188 prisoners that night, that he did not have to conduct a physical check. On arriving on duty he simply checked the cell doors to ensure they were secure, but did not check on the prisoners. He attributed this to the local Night Operating Instructions and local training and said no staff did this as it was custom and practice not to.

77. However, the prison's Night Procedures say that the prison roll will be checked at night between 8.45pm and 11pm, between 11pm and 5.00am and between 5am and 7.30am. It also states that the purpose of the check is to ensure that the roll is correct (i.e. that they have the correct number of prisoners) and the well being of each prisoner is confirmed. The procedures go on to say that,

> "It is not expected during this count that the identity of the prisoner is checked as a matter of routine, however it is expected that the wellbeing of the prisoner is checked. Night patrols should satisfy themselves that breathing or movement is noted."

It also quite clearly says that "Staff are accountable for any prisoners they sign for."

78. Therefore, it seems very clear from this document that staff are expected to conduct a physical roll check and ensure the wellbeing of prisoners at both the start and end of their shift. If they do not, it is not possible for them to account, with any confidence, for the safety of the prisoners in their care. The officer seemed unclear about the old and revised procedures, although he attempted to make the distinction clear to my investigator. I recommend that to avoid confusion the Governor should revise the Night Procedures to clearly instruct staff of their duties of a night, and if the revision has already taken place, then staff should be directed to the revision in the form of a notice to staff or a training event.

79. In addition to the above, it is also confusing that the Night Operating Instructions Checklist, that the officer completed on 17 August, asked staff to confirm:

> "I have carried out a full physical check of all external doors and confirm that they are secure and locked at the commencement of my duty and

once more during my shift. I have visually and manually checked each cell door and confirm they are locked, bolted and secure."

80. This clearly seems at odds with the Night procedures. It may be that there are two sets of documents, but as neither is dated, it is difficult to determine which is the correct version. It is therefore not surprising that staff appear to have been confused about what was required of them. Although there is nothing to suggest that a physical check on the man earlier that morning could have prevented his death, it is the case that in other circumstances a life may be saved if it is known at an earlier point that a prisoner's welfare may be at risk.

The Governor should ensure that the Night Procedures regarding roll checks are clearly drafted to ensure staff know how to conduct a roll check, and this information is cascaded to all night staff.

The man's disability

81. On reception the man was asked about any disability he might have, but he signed the Disability Questionnaire to say that he did not have a disability that he wished to disclose at present. Despite this, staff remembered him from his previous time in custody at Hewell, and he was accommodated in a cell from where he could move around the wing freely.

82. He was allocated a single cell because the Cell Sharing Risk Assessment (CSRA) advised this and had always done so since his first time in custody at Hewell. This is because it was noted that he was difficult to manage and had poor personal hygiene. The CSRA also said that he was as likely to harm someone else as he was himself, as he could be volatile.

83. There is no evidence from prison documentation or from accounts from staff that he suffered from any seizures whilst at Hewell.

Support for family

84. Regrettably the man's family felt they were given incorrect information by the prison about how he had died, that they did not receive the condolence card from prisoners in a timely fashion and that there were problems at the undertakers. After speaking to staff at Hewell these appear due to human error and the prison have apologised to the family for any additional distress that may have been caused.

CONCLUSION

85. This was not the man's first time in custody at HMP Hewell, and many staff remembered him. He was described as a likeable man, who could make people laugh but could also be very frustrating.

86. During his short time at Hewell on this occasion, he presented to healthcare often and was regularly given paracetamol. It is not clear why he was given this medication and what he was complaining of. However, he was examined by a doctor on 16 August after initially complaining of pains in his chest. During the doctor's examination it appeared that the pain was in his side. The doctor prescribed ibuprofen (a painkiller) and to drink plenty of fluids.

87. Throughout his time at Hewell no attention was paid to his past medical history, his notes were not called for, and staff seemed satisfied that he had effectively signed a disability disclaimer. However, they knew enough of him to allocate him a single cell in a location where he had easy access to everything he needed on the wing. It is disappointing that more was not done by healthcare to find out about his mental health needs, his previous medical history and his disabilities.

88. He appeared to have a generally positive rapport with staff on the wing, and they treated him with kindness and understanding.

89. The post mortem report found no significant toxicology findings, which suggests that he had not taken any medication excessively. However, it was unable to establish an exact cause of death. The pathologist was of the opinion that he died from cardiomegaly in association with prior cerebral infarction, an enlarged heart associated with the stroke he had previously suffered

RECOMMENDATIONS

To the Head of Healthcare

1. The Head of Healthcare should ensure that a prisoner's medical records are obtained, particularly when there is an obvious history of illness, mental health issues or a disability.

The prison partially accepted this recommendation. They said that "We do not have the resource to request the medical records for every patient admitted into prison. Records are requested on a needs led basis where the patient assessment and information we have indicates that further information may be helpful."

2. The Head of Healthcare should ensure that the reason for administering medication to prisoners is recorded in the medical record.

The prison accepted this recommendation.

To the Governor

3. The Governor should ensure that the Night Procedures regarding roll checks are clearly drafted to ensure staff know how to conduct a roll check, and this information is cascaded to all night staff.

The prison accepted this recommendation.