PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent investigations

Investigation into the death of a man at HMP Stafford in February 2012

Report by the Prisons and Probation Ombudsman for England and Wales

October 2012

This is the report of an investigation into the death of the man at HMP Stafford in February 2012. The post-mortem examination concluded he died from ischemic heart disease. I offer condolences to his family and friends.

The investigation into the man's death was carried out by one of my investigators. A clinical review of his medical treatment while in custody was conducted. The clinical reviewer cooperated fully with this investigation.

On the morning of the man's death, an officer conducted a roll check of the man's cell but assumed he was asleep. Another officer unlocked the cell 45 minutes later but did not recall looking in. The man was subsequently found unresponsive in his cell at approximately 8.30am by another prisoner who raised the alarm. Resuscitation was performed by officers, a nurse and a doctor in his cell. He was pronounced dead at 8.45am.

The man had been in custody since July 2009 and had not had any significant health problems. He had no apparent symptoms of heart disease immediately before his death. The clinical review concludes that there was no evidence that any medical intervention would have affected the outcome and his care was equal to that he could have expected in a community setting. The investigation identifies a number of areas for potential improvement, including the need for officers to check on the wellbeing of prisoners when unlocking cells and for Stafford to introduce an emergency code. Sadly, I acknowledge that it is unlikely that either of these matters would have altered the outcome for the man.

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.

Nigel Newcomen CBE
Prisons and Probation Ombudsman **October 2012**

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SUMMARY

1. The man was remanded into custody in July 2009. He was sentenced to a minimum of 33 months imprisonment in January 2010. He initially went to HMP Hewell and then to HMP Stafford in March. His behaviour was excellent and he worked as a wing cleaner. In January 2012, he became the cleaning supervisor on the wing.

2. The man had recently completed a challenging offending behaviour programme while in custody as part of his sentence planning. This had distressed him and he had spoken of disturbed sleep and painful childhood memories. The week before he died he had a mental health assessment. The nurse concluded he was at low risk of harming himself but intended to refer him to a psychotherapist. He saw a member of healthcare to discuss giving up smoking the day before he died.

3. On the previous evening before the man died he'd played cards with other prisoners before being locked up at approximately 7.45pm. The following morning, he was seen lying in bed and was assumed to be asleep by the officer carrying out a roll check at 7.15am. About 45 minutes later, his cell was unlocked, along with the other wing cleaners, in preparation for the day. The officer did not recall looking in his cell when he unlocked him.

4. Another cleaner went to the man's cell about 15 minutes after he was unlocked as he was surprised not to have seen him. He realised that something was wrong and immediately alerted an officer who went to the cell. The officer shouted to the nurses on the floor below for urgent medical assistance. They reached the cell with the emergency bag very quickly, along with other staff who had been alerted. The senior officer called an emergency code over the radio (although the prison did not operate an emergency code system) and asked for an ambulance to be called.

5. The man was unresponsive and no pulse was found. Cardio pulmonary resuscitation (CPR) was performed by officers and nurses and also by the prison doctor. Ambulance staff arrived at the cell at 8.34am. He was pronounced dead by the doctor at 8.45am.

6. We make four recommendations. First, that officers check prisoners for a response when unlocking their cells. Second, that an emergency code system is introduced. Third, that a check is made of the suitability of prison beds for administering CPR. Finally, that families should wherever possible be informed of the death of a prisoner in person rather than over the telephone.

THE INVESTIGATION PROCESS

7. The investigator visited HMP Stafford on 6 March to begin the investigation. She met the Governor of Stafford, and the investigation liaison officer. She visited the wing where the man lived but was unable to enter the cell which remained locked at the request of the police as the cause of death had yet to be established.

8. Notices explaining the investigation were issued. No-one came forward with any information in response.

9. HM Coroner for the Staffordshire South district was informed about the investigation and provided the results of the post-mortem investigation. The investigator liaised with the investigating police officer who provided copies of police statements from staff and prisoners. The West Midlands Ambulance Service provided a copy of their incident report.

10. The clinical reviewer and the investigator jointly interviewed three medical staff and one officer on 10 April. The investigator interviewed another officer separately.

11. One of the Ombudsman's family liaison officers contacted the man's next of kin, his ex-wife, to explain the investigation process on 21 March. His ex-wife had no issues to be considered as part of the investigation, but asked for a copy of the draft report. The man had given the details of one of his sisters to be contacted in an emergency (as opposed to his next of kin) and the Ombudsman's family liaison officer also wrote to her. No response was received.

12. A copy of the draft report was sent to the man' next of kin, his ex-wife. She had no comments to make on the report.

13. A copy of the draft report was sent to the National Offender Management Service (NOMS). All the recommendations were accepted and the responses have been repeated verbatim in the recommendations section of this report.

HMP STAFFORD

14. HMP Stafford is a category C training prison which holds up to 741 prisoners across seven wings. E and F wings, known as the Crescent, accommodate prisoners regarded as vulnerable, usually because of their offence. Healthcare is provided by Staffordshire and Stoke-on-Trent Partnership Trust and commissioned by Staffordshire Cluster of Primary Care Trusts.

15. At the last inspection of Stafford in July 2011 HM Inspectorate of Prisons found that the prison was reasonably safe and respectful with a purposeful training regime. Vulnerable prisoners mostly felt safe and had a good regime. Health services were judged to be good. The most recent Independent Monitoring Board report for 2010-11 was also positive about health services at the prison.

16. Since 2004, the Ombudsman has investigated eleven deaths at HMP Stafford. Three of these deaths were self-inflicted, the rest were due to natural causes. The investigation of a death in January 2012 also drew attention to the need for an emergency code system.

KEY EVENTS

17. The man was remanded to HMP Hewell in July 2009. It was his first time in prison. During his first reception health screen, he asked to see a doctor because he was experiencing anxiety and low mood. It was noted that he had chest pains, possibly caused by anxiety. An ECG (an electrocardiogram, which measures the electrical activity of the heart and is used to detect heart problems) carried out was normal. The following day, the doctor prescribed a low dosage of an anti-depressant, which the man stopped taking in December 2009.

18. The man was sentenced in January 2010 to an Indeterminate Sentence for Public Protection with a minimum tariff of 33 months. In March, he transferred to the vulnerable prisoners' wing of HMP Stafford.

19. In July 2010, the man suffered from back pain and was diagnosed with sciatica (lower back or leg pain caused by pressure on the sciatic nerve). Following a physiotherapist assessment in August, he was referred for a MRI scan (a magnetic resonance imaging scan used to diagnose health conditions that affect the organs, tissues or bones). In January 2011, he cancelled the scheduled MRI scan as the symptoms had resolved themselves. During the autumn of 2011, he participated in a Sex Offender Treatment Programme (SOTP). In November, he spoke to the course leader about experiencing disturbed sleep since attending the course. She said she would speak to healthcare, but there is no record of any conversation.

20. The man's conduct during his time in custody was always excellent. In January 2012, he was made the head orderly on the wing and, as a result, was given a single cell. He was well known to the staff.

21. In January, the man was referred for a routine primary care mental health assessment following a discussion with the prison doctor. He spoke again of broken sleep, nightmares and distressing childhood memories. Having completed the SOTP course, the man felt he might need counselling. He was not assessed as at risk of self-harm. He was seen in February by Nurse A, who completed an anxiety and depression questionnaire. He was not considered to be a self harm risk but the nurse intended to refer him for a psychotherapist assessment due to childhood abuse, although this had not been done at the time of his death.

22. On 28 February, the man attended the smoking cessation clinic and was due to start the programme the following week. That evening, he played cards with the other cleaners until about 7.30pm, when they were locked up for the night. He was described as his usual self.

23. The following morning, Officer A started the roll check on the first and second landings at 7.20am. The purpose of a roll check is primarily focused on security and to confirm the presence of the correct number of prisoners. Stafford's local policy in relation to the roll check is for staff to "assure themselves that prisoners are in cells". Between 7.25am and 7.30am, the officer observed the man through the observation flap and saw he was in bed. He described being able to see the top of his head, his left leg and arm and assumed he was in a natural sleeping position. He continued with his roll check.

24. Between 8.10am and 8.15am, Officer B unlocked the wing cleaners. He unlocked the man's cell and recalled:

> "I opened his door by about a third and said "Good Morning", I can't remember if I saw him at the time as I do like to give them a bit of privacy on opening up".

25. Another cleaner went to the man's cell at about 8.25am as he was surprised not to see him up and about. He stood at the door and called out to him a number of times. Getting no response, he went to the office, just next to the cleaners' cells, and alerted Officer B. The officer immediately went into the cell. He saw the man's mouth was rigid and thought he was dead. He went to the cell door and called for urgent medical assistance. He returned to the bed and checked the man's pulse, which he was unable to find. He returned to the cell door and again shouted for medical assistance.

26. Officer C was on the landing below and on hearing the call, went upstairs. He stopped very briefly at Senior Officer (SO)'s office to alert her. She immediately put out a "code blue" call, (an emergency call usually used to inform staff that someone is not breathing) over the radio and asked for an ambulance. The ambulance log indicates the call was received at 8.29am.

27. Nurse A was in the treatment hatch on the landing below, diagonally across from the man's cell and heard Officer B's shout for medical assistance. She locked up and collected Nurse B from the GP room opposite the treatment hatch. Nurse B took the emergency bag with her. They reached the man's cell within a minute of hearing Officer B's shout.

28. Nurse A followed Officer C into the cell and observed the man was not breathing and was slightly grey. They turned him onto his back on the bed. Officer C started chest compressions and Nurse A prepared and attached an oxygen mask. Nurse B helped get equipment out of the bag. A number of staff who had responded to the code blue stood outside the cell. Unlocked prisoners were returned to their cells.

29. The SO made her way along the wing to collect the defibrillator. She met the physical education instructor, who was trained in using it and he returned with her to the cell with the machine. The defibrillator was attached but indicated no shockable rhythm so staff continued with cardio pulmonary resuscitation (CPR).

30. A prison doctor arrived at the cell. He described the man as cyanosed (blue colour to the skin) and said his jaw appeared rigid when he assisted with the airway. The officers asked the doctor whether the man should be moved onto the floor (often considered more effective when carrying out CPR) but he told them the bed was hard enough.

31. At 8.34am, paramedics reached the cell. They asked for the man to be placed on the floor which staff did. The man was pronounced dead at 8.45am by the doctor.

32. A hot debrief for staff took place later that morning with members of the care team present.

33. The prisoner who had found the man was spoken to at length and supported. Prisoners were offered Listeners and all those subject to suicide monitoring procedures were reviewed. In accordance with the man's religion, a Buddhist service was carried out on the wing.

Family contact

34. The man named his ex-wife as his next of kin. The prison family liaison officer telephoned her to tell her of his death, arrange to visit her and explain the circumstances. He visited her that morning. According to national guidance, the prison family liaison officer should have broken the news of the man's death to his family in person rather than over the telephone. He told the investigator that he wanted to confirm the address and make sure she was at home.

35. The prison family liaison officer also contacted the man's brother and sister. A number of prison staff attended the funeral which was led by a member of the prison's chaplaincy. The prison assisted with the cost of the funeral. The man's ex-wife visited the prison and his possessions were returned to her.

ISSUES

Finding the man

36. The officer who carried out the roll count at about 7.25am thought that the man was asleep. Officer B, the officer who unlocked the man's cell 45 minutes later, was unable to recall if he had even seen the man.

37. For their own safety, officers are supposed to look at and make contact with a prisoner through the observation hatch before opening a locked cell door. This is a security precaution, in case the prisoner is waiting to assault them. It also supposed to be a check on the prisoner's wellbeing.

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38. The man was found by another prisoner about 15 minutes later who raised the alarm. Had staff carried out their duties properly, the prisoner would not have been put in this unfortunate situation. However, it does not appear that it would have affected the outcome for the man. The clinical reviewer notes that "according to the medical records it appears that when the man was discovered in his cell there were early signs of rigor mortis as evidenced by a stiff jaw and cyanosis". This suggests that the man was likely to have died even before the roll count. Nevertheless, officers are required to get a response from prisoners when they open the cell. The man could have been discovered earlier had they done so and, in another case, this might save a life. We make the following recommendation:

    The Governor should ensure that when a cell door is unlocked, staff satisfy themselves of the safety of the prisoner and that there are no immediate issues that need attention

Resuscitation

39. CPR is considered to be more effective when carried out on a solid surface. The two officers present asked the prison doctor whether they should place the man on the floor, which can also provide more space, but the prison doctor had assessed the bed to be a suitable surface. The ambulance staff asked for the man to be placed on the floor when they arrived in the cell and staff moved him immediately.

40. The clinical reviewer concludes that it was "highly improbable" that resuscitation would have been successful, given the man's presentation when he was found. Nevertheless, she suggests that the beds should be assessed to see if they are suitable for performing CPR and staff told of the outcome of the assessment. The usual guidance to prison staff is that moving a prisoner to the floor is preferable. Nevertheless, in the light of the advice from the doctor prison staff at Stafford need to be aware of what is the best option. We make the following recommendation:

    The Governor should ensure that an assessment is made whether the prison beds provide a suitably firm surface for CPR and brief all staff about the outcome and the optimal conditions for undertaking CPR.

The man's heart disease

41. The clinical reviewer examined whether the man had any symptoms of heart disease or whether screening would have indicated that he was at risk. She concludes that assessments were carried out effectively and the man had displayed no signs of heart disease. The man's only known risk behaviour linked to heart disease was smoking. He had seen a healthcare worker the day before his death to discuss giving up smoking.

42. Applying a screening tool retrospectively, the clinical reviewer concludes that screening would have classified the man at low risk of developing heart disease as he had not been diagnosed with diabetes, heart disease, chest complaints or high blood pressure. He also had no reported family history of heart disease. We agree with the clinical reviewer that his heart disease could not reasonably have been detected before his death.

Emergency code system

43. Officers do not use a radio code system for emergencies at Stafford prison. Medical staff are alerted to an emergency by either a radio call for medical assistance or a call to hotel 1 (the term used for the nurse holding the emergency radio). By contrast, South Staffordshire PCT's CPR policy states that prison staff will raise the alarm using an emergency code blue or red.

44. When the man was found, the officer shouted out for the assistance of two nurses nearby. A short time later, the SO put out a radio call for a code blue, despite staff not being familiar with this term and there being no emergency code system in operation in the prison.

45. It is good practice for prisons to operate an emergency code system. This affords staff advance warning of the nature of the emergency and what equipment will be needed. One SO did use a code system, but most staff did not understand it. As resuscitation was unlikely to be successful on this occasion, the outcome for the man was not affected. In future emergencies, such confusion could delay the response. We understand that the National Offender Management Service (NOMS) is considering the implementation of a national emergency code system. In the meantime, we make the following recommendation:

The Governor should ensure an emergency code system is introduced.

Family Contact

46. The prison family liaison officer telephoned the man's ex-wife, his next of kin, to let her know of his death rather than breaking the news in person. The reasons given – to check the address and that she was at home could apply to all deaths in custody. Although he visited shortly afterwards, this was not good practice and not in line with Prison Service guidance. We make the following recommendation:

The Governor should ensure that, where practicable, news of deaths at the prison is given to the next of kin in person.

CONCLUSION

47. The clinical review concludes that the man had no symptoms of cardiac disease and that retrospective assessment of cardiac risk factors indicated that the man's cardiac risk was low.

48. We are concerned that there was at least one opportunity for staff to have found the man earlier, if correct procedures had been followed. In the event, it is unlikely that the outcome for him would have been different, but in another case a life might have been saved and, in any case, it should have been staff, rather than a prisoner who discovered him that morning. Similarly, best practice would have been for emergency codes to be introduced at Stafford and for next of kin to be informed of a death in person.

RECOMMENDATIONS

1. The Governor should ensure that when a cell door is unlocked, staff satisfy themselves of the safety of the prisoner and that there are no immediate issues that need attention.

   Accepted by NOMS.

   A staff information notice will be issued informing staff of the requirement to gain a response from prisoners during roll checks.

2. The Governor should ensure that an assessment is made whether the prison beds provide a suitably firm surface for CPR and brief all staff about the outcome and the optimal conditions for undertaking CPR.

   Accepted by NOMS.

   The Head of Safer Custody and the Head of Healthcare will assess the suitability of the beds and publish a notice informing staff of the optimal conditions for undertaking CPR.

3. The Governor should ensure an emergency code system is introduced.

   Accepted by NOMS.

   An emergency code system will be introduced.

4. The Governor should ensure that, where practicable, news of deaths at the prison is given to the next of kin in person.

   Accepted by NOMS.

   Family Liaison staff have been advised that where practicable, and dependant on circumstances, news of deaths at the prison should be given to the next of kin in person.