PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

Investigation into the death of a man at HMP Standford Hill in May 2012

Report by the Prisons and Probation Ombudsman for England and Wales

December 2012

This is the report of an investigation into the death of a man who died at HMP Standford Hill in May 2012 after collapsing suddenly in his cell. The post mortem report gave the cause of his death as heart disease. I offer my condolences to all those affected by his death.

The investigation was carried out by one of my investigators. A review of the man's clinical care in custody was completed by a clinical reviewer. Standford Hill co-operated fully with the investigation.

The clinical reviewer does not identify any deficiencies in the healthcare offered to the man before his collapse. However, he has serious concerns, which we share about the emergency response.

When prison officers were alerted to the man's collapse they assumed he was dead and made no attempt to resuscitate him or seek out a member of staff with cardiopulmonary resuscitation (CPR) training. No one thought of using a defibrillator which was available nearby. Some prison staff wrongly assumed that the man had collapsed nearly two hours earlier when in fact it could have been no longer than 20 minutes.

The investigation has highlighted a lack of defibrillator and CPR training for senior officers. The failure of prison managers to deliver this training influenced the decisions that staff took after the man collapsed, resulting in an inadequate emergency response. While we cannot know whether it was possible to save the man, prison staff did not consider resuscitation and lacked a basic understanding of what to do when a person is found in a state of collapse. The actions of the staff involved and the role of managers is now subject to a Prison Service disciplinary investigation which I would otherwise have recommended.

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 **December 2012**

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SUMMARY

1. In January 2012, the man received a ten month prison sentence at Maidstone Crown Court and was taken to HMP Elmley on the Isle of Sheppey. He told healthcare staff that he suffered from chronic obstructive pulmonary disease and an under-active thyroid. He also had a chest infection. Doctors prescribed appropriate medications for these conditions.

2. On 10 February, the man transferred to HMP Standford Hill, an open prison adjacent to Elmley. He was assessed by a nurse during the reception process. During the next three months, he attended several appointments with healthcare staff but did not complain of any additional serious health problems.

3. On the day the man died he did not report any discomfort during the day. He then seems to have gone to his cell at about 6.00pm. Prisoner A discovered him collapsed on his bed at about 6.25pm and hurried to the wing office to alert prison staff.

4. There were no nurses on duty when the man collapsed because they had finished their shift as usual at 5.00pm. Three officers and two senior officers attended the man's cell, but none of them attempted cardiopulmonary resuscitation (CPR). The first two officers to arrive at the scene checked for a pulse but could not find one and assumed he had died. An ambulance was called immediately.

5. The orderly officer in charge of the prison did not examine the man, accepted that he had died and left wing officers in charge of the cell. A physical education (PE) instructor working in the gym next door was trained to perform CPR and use a defibrillator, but he was on his own and not easily able to leave his duties when the emergency was first announced. Staff at the scene did not make any subsequent requests for a CPR trained member of staff because of their presumption that the man had already died. A paramedic arrived at 6.49pm and pronounced the man dead at 6.58pm.

6. Prison staff subsequently encountered problems locating the man's next of kin, but eventually contacted a friend and the man's step-daughter.

7. The investigation has highlighted serious concerns about the emergency response. There was a woeful lack of first aid trained staff at the prison which urgently needs to be rectified. Officers on duty did not understand the circumstances in which resuscitation should be attempted and simply presumed that the man had died when they could not find a pulse without starting CPR. No one tried to ensure a first aid trained member of staff was brought to the scene or thought of using a defibrillator from the wing office. We make five recommendations as a result of the investigation.

THE INVESTIGATION PROCESS

8. The investigator was told about the man's death on Monday 28 May 2012. Notices were issued to staff and prisoners at HMP Standford Hill telling them about the investigation process and inviting them to contact the investigator. No one came forward as a result.

9. The investigator liaised with Principal Officer (PO) A, the Governor and the Deputy Governor during the investigation. He visited Standford Hill on Tuesday 29 May to collect paperwork relating to the man's time in custody. He also spoke to the Governor, visited the man's cell and spoke to Prisoner A, the prisoner who found the man collapsed.

1. A clinical reviewer was commissioned to carry out a review of the clinical treatment the man received while in custody.

2. On 26 June, the investigator visited Standford Hill to interview six members of prison staff. He also went to Sittingbourne Ambulance Station to interview the paramedic who had attended the emergency. He spoke to the Deputy Governor and subsequently provided written feedback about the progress of the investigation to the Governor. One of the interviewees, Senior Officer (SO) A, subsequently wrote to the investigator enclosing further evidence relevant to the man's death.

3. The investigator wrote to inform the local Coroner about the investigation, who will be provided with a copy of this report.

The man's next of kin

4. Prison staff had difficulties locating the man's next of kin because he had not identified them. Eventually they were able to contact a friend and then his step-daughter. One of the Ombudsman's family liaison officers spoke to the man's friend who did not raise any concerns for us to address. She was unable to make contact with the man's step-daughter.

5. We offered to provide the man's next of kin with copies of our draft report when it was published. As we publish our final version of the report in early December 2012, they have not yet asked to see it. We will of course be able to provide them with a copy of it whenever they contact us again.

HMP STANDFORD HILL

6. HMP Standford Hill is an open prison on the Isle of Sheppey, Kent, holding up to 462 male prisoners. It is part of a group of three prisons along with HMP Elmley and HMP Swaleside. As an open prison, prisoners are routinely trusted to move around the site unescorted and to travel on their own to work placements and hospital appointments. Healthcare staff work between 8.00am and 5.00pm from Monday to Friday. There are no healthcare staff on duty during the evening, overnight or at weekends, although an out of hours service is available. A part time doctor works on Mondays, Wednesdays and Fridays.

Independent Monitoring Board (IMB)

7. The prison's Independent Monitoring Board (IMB, a group of unpaid local people who independently monitor and report on the prison) commented in their most recent annual report:

> 'The prison has benefited from good, stable and, in some cases, innovative management. The Board feel the prison is well run and moving forward.'

HM Inspectorate of Prisons

8. The Inspectorate of Prisons completed an announced inspection of Standford Hill in December 2011. In his introduction to the report HM Chief Inspector of Prisons wrote:

> 'A sense of disinterest too often permeated… aspects of the prison.
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> 'Until relatively recently, Standford Hill appears to have been coasting. Outcomes are reasonable in most areas but the prison is exposed by some significant areas of concern. Reassuringly, almost nothing we said in our immediate feedback to the new governor came as a surprise and work had already started to address the concerns we identified. It was overdue and it is to be hoped that a period of more stable management will enable the prison to make the rapid progress required.'

9. Inspectors noted that as well as in healthcare, "AEDs (automatic external defibrillators) were sited in the A wing control room and gym. The equipment was checked routinely, except for the one on A wing, which was dusty and had not been checked since July 2011. On A wing, only two wing-based staff had been trained to use the AED, so it was not always possible to have a trained person available at all times." The Inspectorate recommended that staff should be trained in the use of defibrillators, which should be cleaned and checked regularly.

Previous deaths at Standford Hill

10. Until February 2012, no prisoners from Standford Hill had died since 2007. We have recently investigated two other deaths at the prison in addition to the man's, and a subsequent death is also being investigated. There are no significant similarities between the circumstances of the man's death and those of the other men.

KEY EVENTS

11. A warrant for the man's arrest was issued on 6 April 2005 after he was convicted in his absence for fraudulently evading duty on goods. He was eventually arrested on 19 January 2012. On 20 January, he was sentenced to a total of ten months imprisonment at Maidstone Crown Court. He received two months for absconding and eight months for the long standing fraud conviction. The man was due to be released from custody at the halfway stage of his sentence on 20 June and was eligible for release on home detention curfew (HDC) on 6 April.

HMP Elmley

12. The man was taken from the court to HMP Elmley. During the reception process, Nurse A assessed the man. He reported a diagnosis of chronic obstructive pulmonary disease (COPD). The nurse issued him with a salbutamol inhaler. The man also said that he suffered from hypothyroidism (an under-active thyroid), for which he was taking levothyroxine. He explained that he had previously suffered from throat cancer but had been given the 'all clear' by his consultant at the Queen Elizabeth Hospital in Birmingham in October 2011.

13. The next morning, 21 January, the man was seen by Healthcare Assistant A and then by Dr A. The doctor recorded that the man looked well and was not short of breath. He told the man to report any concerns to staff if his health worsened. He prescribed salbutamol, spiriva and clenil modulite for his COPD, levothyroxine for his hypothyroidism and amoxicillin (an antibiotic) for a chest infection.

14. Nurse B saw the man on 23 January. She checked his inhalers, recorded that he was taking amoxicillin for his chest infection and noted that he would undergo a lung function test once the infection had cleared.

15. On 30 January, healthcare staff requested a copy of the man's clinical record from his GP surgery in Birmingham. The same day, Nurse B saw the man again and he was still wheezy, congested and chesty. She postponed his lung function test because his chest had still not cleared and referred him to the doctor. She noted that the man smoked 20 to 30 cigarettes each day and did not want to stop smoking. Dr B examined the man later that day and prescribed prednisone (oral steroids) and budesonide (a drug used to treat breathing problems). On 5 February, the man's lung function test was carried out and in his clinical record described the results as routine.

HMP Standford Hill

16. On 10 February, the man transferred to Standford Hill, an open prison adjacent to Elmley. Nurse C completed a routine reception health screen and recorded the man's diagnoses of COPD and an under-active thyroid. She noted that he did not want to stop smoking. The nurse planned a referral to

the asthma clinic and recorded that the man should limit himself to restricted physical activity.

17. On 28 February, the man saw Nurse D as he felt generally unwell and had a headache and shivers. The nurse took his temperature and listened to his chest, which was clear. She diagnosed an upper respiratory infection and prescribed paracetamol, three days rest and plenty of fluids.

18. On 12 March, a member of staff from Standford Hill's healthcare department checked the man's lung function and prescribed additional inhalers. The man saw Dr D on 23 March. The doctor recorded that the man could do only a limited amount of exercise, that his temperature was normal and that he still smoked 20 cigarettes each day. The doctor strongly advised the man to stop smoking and prescribed further courses of prednisone and spiriva to help his breathing.

19. Dr E saw the man on 30 March. The doctor thought that the man's COPD was worsening and that he was probably suffering from peripheral vascular disease (obstruction of the large arteries which carry blood around the body). The doctor advised the man to stop smoking and planned a chest X-ray and ultrasound checks on his lower limbs. The man's feet were tinged blue because of his failing circulation.

20. The man was eligible for release from prison under the Home Detention Curfew (HDC) electronic tagging scheme on 6 April. He was a low risk offender with no history of sexual or violent offending. However, the man had no release address and neither Birmingham (where he used to live) nor Kent Probation Trusts would accept responsibility for him. Ultimately, the man arranged a one bedroom flat for himself in Dartford for his release date. Efforts to secure an early HDC release were abandoned with his agreement as he indicated that he preferred to be released without restrictions to a permanent address at the halfway stage of his sentence, rather than to be released early to a hostel where he would be tagged and subject to a curfew.

21. On 16 April, the man attended Sheppey Community Hospital for his chest X-ray. The results were abnormal as expected but consistent with his diagnosis of COPD. The man's lungs were over-inflated but his heart was not enlarged. The man visited Sheppey Community Hospital again for an X-ray of his shoulder on 23 April.

22. On 15 May, the man was assessed as unfit for work by Nurse E. He had a cold and a headache but had no symptoms of a chest infection. She prescribed paracetamol and advised the man to rest in his cell for 24 hours. Two days later, Nurse F prescribed further paracetamol and a vapour rub.

The day of the man's death

23. Prisoner A had transferred with the man from Elmley in February and they had become friends. He described the man to the investigator as a frail and thin man who smoked all the time. Prisoner A told the investigator that he saw the man at about 8.30am on the day of the man's death, when they had coffee and a cigarette. He also saw the man at about midday for lunch and at about 4.30pm when they both collected their meals at teatime. On all three occasions, he remembered that the man had seemed his normal self and did not complain of any pain.

24. At about 4.45pm Officer A completed the afternoon roll check on the second landing of A wing where the man had a single cell. She accounted for all prisoners including the man. None of the wing staff saw the man again before his collapse.

25. The man is recorded on CCTV footage returning to his cell for the last time at 6.02pm. At 6.24pm, prisoner A went to see the man and found his cell door wide open. He described the man as lying on his back on the bed with his right leg off the bed. His hands were reaching out with his fingers bent. His eyes were open and a gurgling noise was coming from his mouth. Prisoner A realised that his friend was seriously unwell.

26. Prisoner A left the cell to look for an officer. There was no one on the first or second landings so he hurried to the A wing office in the centre of the building and told Officer A about the emergency. He explained that the man was unwell and was flapping his arms about. At 6.25pm, Officer A went with prisoner A back to the man's cell, followed by Officer B who was also in the A wing office.

27. Officer A told the investigator that when she arrived at the cell, she checked the man's wrist for a pulse. She could not find one and he was not breathing. She tried to rouse him by saying his name, but he was unresponsive. His arms were reaching out, his mouth was wide open and his eyes were staring but not moving. He was very still and was not making any sound. She told Officer B that she thought the man had died.

28. Officer B checked for any rise and fall in the man's chest but saw none. The officer told the investigator that the man looked lifeless. He noticed the smell of excrement and deduced that the man had emptied his bowels. He noticed that the man's face looked grey. He removed the man's false teeth because they had become dislodged in his mouth. He also decided that the man had died. Neither officer considered attempting to resuscitate the man.

29. Officer A radioed SO A who was the orderly officer in charge of the prison, to alert him that a prisoner was not breathing and she thought that he had died. The radio network is switched to talk through after the end of the core day at 5.00pm, meaning that officers can hear each other immediately, rather than messages being relayed by the control room staff.

30. Both of the officers continued to check the man for a pulse but could not find one. Officer A moved the man's right leg back onto the bed so that he was lying completely flat because she was concerned about rigor mortis setting in. Prisoner A was sitting outside the man's cell. He then went for a walk in the prison grounds to recover from the shock.

31. SO A was in the reception area near the prison gate when he heard Officer A's message. She did not use the emergency code system to request help so SO B used his radio to announce, 'All available staff, code blue' as he hurried towards A wing. SO B also radioed the communications room to call an ambulance.

32. SO A was with SO B (the assistant orderly officer) when the call came over the radio, and they both arrived at the cell at about 6.28pm. The ambulance service received a call from the prison at 6.29pm. The call was given to paramedic A at Sittingbourne Ambulance Station at 6.31pm because the Sheppey ambulances were all out on calls.

33. After they arrived at the cell, SOs A and B spoke to Officers A and B, who both said that they could not find the man's pulse. The senior officers accepted what the officers told them and agreed that the man had died. Neither senior officer went to the bed to examine him, but they checked the room to confirm that there were no suspicious circumstances.

34. SO A told the investigator that when he radioed for all available staff to attend the scene he had hoped that somebody with cardiopulmonary resuscitation (CPR) training would come to A wing. He did not specifically request staff trained in CPR and did not check if any of the prisoners could perform CPR. Neither of the senior officers attempted to resuscitate the man themselves, nor did they look for the list of trained first aiders. There was a defibrillator in the A wing office but the prison staff did not bring it or attempt to use it

35. Officer C came from C wing to assist and found the two officers and two senior officers in the cell. Officer C checked the man's wrist for a pulse but said he could not find any signs of life. He checked that an ambulance had been called. He told the investigator that there was no discussion about whether to perform CPR.

36. SO B went to the A wing office and began printing off the contingency plans for a death in custody. SO A left Officers A and B standing outside the cell and began locking the other A wing prisoners in their cells. He also called the communications room to check on the progress of the ambulance.

37. Physical Education Instructor (PEI) was managing about 70 prisoners on his own in the gymnasium directly across the road from A wing. He was the only member of staff in the prison at the time with current CPR and defibrillator training. The PEI said that he heard the call for 'all available staff' on his radio but did hear that it was a 'code blue' emergency. He did not immediately go to assist because he was on his own supervising prisoners swimming and using weights. Also, he thought that the first message was swiftly superseded

by a request for senior officers to attend. The PEI carried on with his work in the gym and then heard over the radio that an ambulance had been requested. He presumed that the situation was now under control and being dealt with. None of the staff at the scene made a request for staff trained in CPR so the PEI remained in the gym.

38. .At 6.46pm, the paramedic arrived at the prison gate and reached the man's cell three minutes later at 6.49pm. 24 minutes had now passed and none of the staff who had gone to the cell had attempted to perform CPR. The man remained on the bed where he was found.

39. Officer A was upset and in shock so SO A sent her to the A wing office. The SO then also left the scene again to return to the A wing office, leaving Officers B and Officer C with the paramedic.

40. The man's face was blue and his fingers and extremities were cold. The paramedic attached a defibrillator but the machine indicated that an electric shock should not be delivered because no heart rhythm could be found. (Defibrillators only instruct the user to shock if a heart rhythm can be detected.) The monitor showed a flatline. The paramedic decided that it was too late to attempt any kind of CPR because too much time had passed without any intervention for him to stand any chance of success. He pronounced the man dead at 6.58pm. .

41. Prison managers offered Prisoner A support from a Listener on A wing, but he chose to speak to his friends for support. SO C from the care team attended A wing to offer support to Officer A, who was still in shock.

42. The man had not identified a next of kin and initially Standford Hill staff were not able to contact any members of his family. Eventually they contacted a friend of the man's in the West Midlands and subsequently located his step-daughter.

43. A memorial service was held in the prison for the man on Wednesday 30 May. The arrangements for his funeral were delayed because of the difficulties encountered in tracking down his next of kin. It was eventually held on Wednesday 1 August in Bobbing, near Sittingbourne.

44. A toxicology report showed that there were no drugs or alcohol in the man's body when he collapsed. The post mortem report concluded that the man died from ischaemic heart disease. (This means that the vessels supplying the heart with blood became blocked with fatty deposits.) Chronic obstructive pulmonary disease (COPD) was recorded as contributing to his death but not directly causing it.

ISSUES

Emergency Code system

45. When Officer A reached the man's cell, she did not use the emergency code system when she initially sent a message over the radio network. SO A told the investigator that it was he who announced a code blue emergency after he received Officer A's initial call for assistance. The PEI told the investigator that he did not hear the announcement of the code blue emergency

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46. On 12 July 2012, the Governor issued a notice to staff reminding them to use code red (when a prisoner is bleeding) and code blue (when a prisoner is not breathing) to identify quickly and correctly the nature of an emergency over the radio network. The use of such codes allows staff attending the emergency to prepare mentally for what they might encounter and helps ensure that appropriate staff attend with the correct equipment.

The failure to attempt resuscitation

47. The clinical reviewer writes in his clinical review that 'radical changes' need to be made to the way in which Standford Hill currently responds to life threatening events such as a cardiac arrest. None of the five prison staff at the scene attempted cardiopulmonary resuscitation (CPR). All rapidly came to the conclusion he was dead. In the 25 minutes that passed between Prisoner A raising the alarm and the paramedic reaching the cell none of the five staff questioned their assumption. They based their opinion on the fact that the man did not have a pulse and was not breathing. They were all quite certain that he had died and consequently it never occurred to them to attempt CPR.

48. Our interviews revealed that some of the staff mistakenly assumed that the man must have collapsed straight after the roll-check at 4.45pm because they had not seen him since then. This unfounded assumption reinforced their belief that he had died. The CCTV footage in fact shows the man returning to his cell for the last time shortly after 6.00pm and Prison A described signs of life when he reported the emergency to staff which would suggest that the man was still alive as late as 6.24pm.

49. None of the five staff at the scene had current CPR training. The most up to date was Officer B, who told the investigator that he had completed a three day course which included CPR within the last few years. Officer A's only experience was an afternoon of training during her original prison officer induction course seven years earlier. Officer C said that he had volunteered for a first aid course about 15 years previously but would not now feel confident attempting resuscitation. SO B estimated he had done a one day course involving CPR techniques about seven or eight years previously, but told the investigator that he had no confidence in attempting resuscitation. The Orderly Officer, SO A, said that the only relevant training he had done was during his prison officer induction course in 1993.

50. Several staff, including SO A who was in charge of the prison, told the investigator that they felt helpless and panicked during the incident. We are concerned about the lack of knowledge of the five staff who attended the scene. They did not have a basic understanding of what it means when somebody has collapsed and does not have a pulse. They equated this with the person being dead, rather than the possibility of a cardiac arrest. They did not seem to understand that a short while after a collapse, the rapid use of CPR techniques can enable the person's heart to start beating again. The clinical reviewer comments in his clinical review:

> 'What [the staff] should have concluded was that [the man] had ARRESTED and this may have been a salvageable situation, especially as this may have occurred only minutes before the officers found the man collapsed in his cell when he was seen by another prisoner making "gurgling noises and waving his arms about".'

51. The Governor replied to the investigator's initial feedback:

> 'Although the staff first on scene had not recently been trained, I find it very difficult to believe that they wouldn't have known what to do in an emergency situation. Within Prison Officer basic training, staff will have undertaken Heartstart Training (if they were trained before 2007) and all of the staff at the scene were trained before this date. I would have at least expected the summoning of trained help as a basic response.'

52. We agree that the lack of an effective response was surprising but we do not accept that reliance should be placed on officers remembering basic first aid skills from training up to twenty years previously. We make the following recommendation:

The Governor should ensure that every member of prison staff receives sufficient training to be able to understand:

- **that immediate cardiopulmonary resuscitation might benefit a prisoner who is not breathing**
- **when to request the help of staff trained in cardiopulmonary resuscitation**

The availability of trained staff

53. The PEI was only yards away across the road in the gym. He was trained to perform CPR and use a defibrillator and the only member of staff on duty with up to date training. He told the investigator that he did not hear SO A announce a code blue emergency. The PEI said that he did hear the request for 'all available staff'. However, he was working on his own in the gym and could not easily leave a large number of prisoners alone with the gym equipment. He was unaware that he was the only CPR trained member of staff available. The PEI then heard requests for senior officers and an ambulance and thought that the situation was under control. The PEI told the investigator that he was very shocked to learn a short while later that the man

had died. The PEI said that no request was put out on the radio network for CPR trained staff.

54. SO A told the investigator that he expected those staff with CPR training to make themselves known over the radio network and offer their assistance. He explained that he would then have made arrangements for this member of staff to be relieved from their duties to allow them to attend A wing. While it would have been helpful for the PEI to have checked whether he was needed, it was the orderly officer's responsibility to seek out CPR trained staff. If the PEI had volunteered, it seems unlikely the SO would have thought it necessary for him to attend, as all the staff involved had made the assumption that the man was beyond saving.

55. Standford Hill's local emergency contingency plan states that the Orderly Officer is required to bring any staff trained in CPR to the scene. The Governor confirmed that the 'Out of hours' emergency procedures had been risk assessed and agreed in February 2010. She added that a notice to staff had been issued at that time. SO A told the investigator that he announced a code blue emergency and asked for all available staff. This was in line with the prison's guidelines, most recently issued in a notice to staff (NTS143/2012).

56. However, because SO A readily accepted the opinion of the two officers that the man had died, he abandoned any further attempts to request, or locate, appropriately trained staff. He told the investigator that he was 'hoping' that these staff would arrive. Neither SO A nor SO B consulted a list of current first aiders (or indeed knew exactly where to find one). They did not know where the defibrillator was or who had been trained to used it. As the orderly officer in sole charge of the prison, SO A should have been familiar with the emergency procedures and known which colleagues were appropriately trained and where to find emergency equipment. Neither of the SOs made any attempt to identify the PEI as the trained member of staff on duty. We make the following recommendation:

The Governor should ensure that a list of staff currently trained in cardiopulmonary resuscitation and the use of a defibrillator is prominently displayed in every building on site and that all staff are aware of these notices.

The need for training

57. The clinical reviewer writes in his clinical review:

> 'Unfortunately one will never know… if CPR had been immediately commenced by the prison staff after they had been told that the man had collapsed, whether it might have been successful and restored [his] circulation.'

58. It is possible that the man had already died and nothing would have helped. However, we are concerned that he seems to have still been alive when

Prisoner A left him to get help, and it was only a minute or so later when Officer A arrived in the cell. On their way back to the cell, Prisoner A told the officer that the man had been flapping his arms around.

59. The investigator interviewed the paramedic A. He was very concerned that prison staff had not tried to resuscitate the man simply because he did not have a pulse. The paramedic explained that he did not stand a chance of reviving the man because prison staff had not performed CPR for the previous 24 minutes. He thought that prison staff urgently required basic training so that they understand what help should be given. None of the five members of staff at the scene had a basic understanding of cardiac arrest and the benefits of resuscitation. Neither senior officer was CPR trained, and this had a direct impact on their ability not only to deliver CPR, but also to understand why it should be attempted in the first place.

60. The investigation found that Standford Hill was frequently left with no CPR trained staff during parts of the evening during May 2012. On the evening the man died, the PEI was due to leave the prison at 7.30pm. After this time, there would have been nobody on site with CPR training.

61. We consider that as there is always a senior officer on duty, at minimum all senior officers should receive CPR training. This would ensure the constant presence of a CPR trained member of staff. A 'First Aid Needs Risk Assessment Form' completed on 24 January 2011 by the then health and safety advisor instructed that all senior officers were to be trained in 'Emergency First Aid at Work' as soon as possible. This had still had not happened when the man died 16 months later. Following receipt of our interim feedback letter about the man's death, the Governor instructed that all senior officers should be emergency first aid trained by the end of July 2012.

62. Staff did not collect the defibrillator from the A wing office and some of them did not even know where it was located. All of the five staff at the scene were afraid to use a defibrillator and said they needed training. None had ever been shown how to use one. Although there was a suggestion during the interviews with prison staff that the defibrillator was outdated, the paramedic told the investigator that he checked the defibrillator in the A wing office immediately after the emergency and thought that it was suitable for staff to use.

63. In January 2012, the Governor wrote to the Head of Residence to advise that the prison required a local defibrillator policy. The Governor recommended that senior officers needed to be trained to use the defibrillator to be called upon whenever healthcare staff were not on duty. She suggested that the prison's PE instructors (PEIs) should train the senior officers to use the defibrillators.

64. Prison managers had made some plans to give the senior officers defibrillator training before the man died, but the training was due to take place shortly after his death. The Head of Residence arranged for the PEIs to attend a course run at the Prison Service School of PE at Lilleshall National Sports

Centre, so that they could deliver defibrillator training to the senior officers. The course for the PEIs was held during the week beginning 4 June 2012. Two members of PE staff are now qualified to deliver defibrillator training and a training programme for officers is now in place. Since the man's death, the Governor has issued a notice to staff reminding them where defibrillators are located and to familiarise themselves with the instructions. Additional defibrillators have been bought for B and C wings, as there were none in place.

65. We have some sympathy with SO A who maintains that he could not have been expected to use the defibrillator without training. Although this is a piece of equipment which instructs the user at every stage, his managers had previously decided that training was required to prepare the senior officers to use it. The SO also maintains that he should have been trained in CPR. The need for the senior officers to be trained had been identified over a year earlier and was not then implemented. SO A, and SO Bs' failure to manage adequately the emergency on 25 May can partially be attributed to senior managers' failure to give them the right training. We make the following recommendation:

The Governor should implement a rolling training programme to ensure that all senior officers and sufficient other front line staff have current training to perform cardiopulmonary resuscitation and use a defibrillator. These skills should be kept up to date by regular refresher training.

Oversight of the emergency scene

66. Instead of considering CPR, the two senior officers began locking up prisoners and preparing death in custody paperwork before the paramedic had arrived. Neither remained at the cell to manage the ongoing emergency. The officers who were left stood outside the cell and nobody monitored the man. We make the following recommendation:

The Governor should ensure that at least one manager attending an incident remains at the scene to coordinate the emergency response.

Contingency plan

67. None of the five staff at the scene were familiar with Standford Hill's local contingency plan which tells them what to do when a prisoner collapses. Some recognized the document and some knew where to find it, but none had read it. They all seemed fearful of touching or moving the man during the emergency and seemed worried that they might be criticised by the police if they disturbed the scene.

68. Local contingency plan 22 ('Emergency removal of a prisoner to outside hospital') states in bold capitals that staff who are not currently CPR trained should not under any circumstances try to resuscitate a prisoner. This advice seems contrary to that given on CPR training, which is that it is always better

to try and help, because things cannot be made any worse for the individual if they are not breathing.

69. If followed, the statement in the contingency plan would prevent staff with out of date training but with a basic grasp of chest compressions and rescue breaths from doing anything to help a prisoner. The Governor told the investigator that she was unable to identify who had written Contingency Plan 22. She accepted that it went against both normal advice and the guidance contained in Standford Hill's own Death in Custody contingency plan. She has withdrawn the plan and made it clear that future contingency plans will need to be signed off by her. We make the following recommendation:

The Governor should ensure that a new local emergency contingency plan is devised and issued to staff with up to date and appropriate advice about resuscitation.

CONCLUSION

70. The man suffered from lung disease and heart disease. He collapsed suddenly while in the care of prison staff. After Prisoner A discovered the man and raised the alarm, prison staff collectively failed to take any action to try to resuscitate him. After checking the man, officers who were first on the scene made an ill-informed assumption that he was dead. Their managers who arrived shortly afterwards did not question this assumption, did not check themselves, did not properly coordinate the emergency response and did not bring appropriately trained staff to the cell. There was a lack of awareness of the importance of immediate CPR.

71. Although there is no healthcare presence in the prison in the evenings and at weekends, managers at Standford Hill had failed to ensure that there were sufficient CPR trained staff on duty at all times to respond to emergencies. CPR training for senior officers was recommended over a year before the man died, but was not implemented. Defibrillator training was also suggested four months before the incident. The Inspectorate had also identified deficiencies in emergency arrangements. We note that the Governor has taken several steps since the man died to correct these problems.

72. Following the man's death, an internal Prison Service fact finding exercise was completed. A Prison Service disciplinary investigation has been instigated to look at the actions of the staff involved and the management processes. We consider that the emergency response was wholly inadequate and we believe that disciplinary proceedings are an appropriate course of action to reflect the seriousness of the failures.

RECOMMENDATIONS

1. The Governor should ensure that every member of prison staff receives sufficient training to be able to understand:

   - that immediate cardiopulmonary resuscitation might benefit a prisoner who is not breathing
   - when to request the help of staff trained in cardiopulmonary resuscitation

   The Governor accepted our recommendation and provided the following response:

   'A Local Policy Document has been re-written to include correct guidance to staff in an emergency situation, including when to seek help from a trained person and emphasises the point that performing CPR at the earliest opportunity will benefit a prisoner who is not breathing. The key points from this document will also be circulated as a notice to staff and feature in the next full staff briefing.

   'We have also trained all Senior Officers (there is always one on duty) in the use of the Defibrillator and Emergency First Aid. Ongoing training for staff is also taking place.'

2. The Governor should ensure that a list of staff currently trained in cardiopulmonary resuscitation and the use of a defibrillator is prominently displayed in every building on site and that all staff are aware of these notices.

   The Governor accepted our recommendation and provided the following response:

   'We will ensure that that a list of staff currently trained in cardiopulmonary resuscitation and the use of a defibrillator is prominently displayed in every building on site and that all staff are aware of these notices. This will also be published weekly via the Governor's Bulletin.'

3. The Governor should implement a rolling training programme to ensure that all senior officers and sufficient other front line staff have current training to perform cardiopulmonary resuscitation and use a defibrillator. These skills should be kept up to date by regular refresher training.

   The Governor accepted our recommendation and provided the following response:

   'All Senior Officers have been trained in cardiopulmonary resuscitation and the use of a Defib since the beginning of August. A programme is in place to ensure that refreshers are given as a rolling programme to ensure continuity.'

4. The Governor should ensure that at least one manager attending an incident remains at the scene to coordinate the emergency response.

The Governor accepted our recommendation and provided the following response:

‘Senior officers and all other operational managers have been briefed to ensure a manager stays at the scene to co-ordinate the emergency response. The Contingency plans also now reflect this.’

5. The Governor should ensure that a new local emergency contingency plan for the removal of a prisoner to outside hospital is devised and issued to staff with up to date and appropriate advice about resuscitation.

   The Governor accepted our recommendation and provided the following response:

   ‘A Local Policy Document has been re-written to include correct guidance to staff in an emergency situation, including when to seek help from a trained person and appropriate advice about resuscitation.

   ‘Local security protocols and contingency plans have been updated to include up to date information on removing a prisoner to hospital.’