Investigation into the circumstances surrounding the death of A man on 9 November 2005 whilst a prisoner at HMP Elmley

Report by the Prisons and Probation Ombudsman for England and Wales

July 2007

This is the report of an investigation into the death of a man on 9 November 2005 whilst a prisoner at HMP Elmley. The man was on remand awaiting trial at the time of his death. The post mortem found the cause of death to have been acute asthma. The man was just 23 years old.

I wish to offer my sincere condolences to the man's family for their loss.

The investigation was conducted on my behalf by one of my investigators. I would like to extend my thanks to the former Governor and his staff at Elmley for their help and co-operation.

In addition to my investigation, a clinical review was undertaken by the Swale Primary Care Trust into the medical care that the man received. I did not feel that the review covered all relevant matters to the extent required and made a recommendation that a further review should be undertaken. I am grateful to the clinical reviewer for providing the second review.

I regret the delay in issuing the first draft report, but the clinical review (which, in any event, I regarded as unsatisfactory) was not received by my investigator until the end of April 2006. This final report incorporates the feedback from the Prison Service and the solicitors acting on behalf of the man's family. The report demonstrates the inevitable risks if a prisoner becomes ill in his cell at night. It also shows how a series of unintentional failures in communication can have a tragic outcome. I make five recommendations.

Stephen Shaw CBE
Prisons and Probation Ombudsman **July 2007**

Contents

Summary

Investigation Methodology

HMP Elmley

Events prior to the man’s death

Events surrounding the man’s death

Events after the man’s death

Clinical review

Findings and conclusions

Recommendations

Summary

The man was remanded into custody on 29 October 2005, accused of an offence of common assault. He was initially sent to HMP Chelmsford. During the reception process, he told staff that he had taken an overdose of his prescribed medication two days previously and had been admitted to hospital.

On 1 November 2005, the man moved to HMP Peterborough where staff opened an F2052SH self-harm monitoring form after he told them about his recent overdose. Following a further court appearance on 7 November, the man moved to HMP Elmley. At Elmley, the man remained on the F2052SH form and he was put into a triple cell.

At 1 am on 9 November, the man rang the cell bell and told the night Operational Support Grade (OSG) that he was having trouble breathing. The OSG contacted the nurse in healthcare, who said that the man had his inhalers and that there was nothing further she could do. She put the man on the list to see the doctor later that morning. The OSG reported back to the man, who apparently accepted what he had been told.

At 5.15 am, one of the man's cell mates rang the cell bell. When the OSG attended on this occasion he saw the man standing by the cell window, obviously having breathing difficulties. The OSG spoke to the nurse again who advised him to ask the Night Orderly Officer to collect her from healthcare so that she could examine the man.

The OSG passed the message to the Orderly Officer, although whether the urgency of the situation was communicated is in dispute. The Orderly Officer arrived about 30 minutes later and saw the man lying on his bed. He did not enter the cell, but had a brief conversation with one of his cell mates. It is likely that the man was at least unconscious by that time.

The Orderly Officer arranged for the nurse to be brought over to the cell. When she arrived about ten minutes later, she found that the man was not breathing. She began trying to resuscitate him and an ambulance was called. The paramedics took over the resuscitation efforts when they arrived at 6.12 am, but without success. They pronounced the man dead at 6.21 am.

The post mortem examination concluded that death was by natural causes as a result of an acute asthma attack.

Investigation Methodology

1. The investigation was opened at HMP Elmley on 17 November 2005. The Governor and his staff produced the man's core record and a large number of other documents for examination. Notices were distributed around the establishment notifying staff and prisoners of the investigation, and a number of prison staff and prisoners were formally interviewed.

2. My investigator liaised with a Detective Inspector, the investigating officer from Kent Police, who was conducting an enquiry on behalf of Her Majesty's Coroner.

3. Her Majesty's Coroner was contacted to inform him of the nature and scope of my investigation and to request a copy of the Post mortem report. Upon completion, this report will be sent to the Coroner to assist with his enquiries into the man's death.

4. One of my Family Liaison Officers contacted the man's family to inform them about my investigation. My investigator and family liaison officer met with the man's parents and younger brother at his mother's London flat in December 2005. My investigator summarised the progress of the investigation to date and what he had discovered of the events surrounding the man's stay at Elmley and his death. My family liaison officer explained his role and noted the concerns that the family had. The man's family could not understand how he could have died from an asthma attack in a three-man cell. The man's father also told my colleagues about bruising across the man's upper chest and a bruise on his face.

HMP Elmley

5. Elmley is a purpose built prison serving all courts in the county of Kent. The prison opened in 1992 and includes a Category C Unit of some 240 prisoners built in 1997 and a Vulnerable Prisoner Unit delivering the Sex Offender Treatment Programme. Elmley is one of the six ‘Bullingdon’ design prisons, and is one of three adjacent jails forming a cluster on the Isle of Sheppey.

6. Her Majesty’s Chief Inspector of Prisons, Ms Anne Owers, carried out a full inspection in 2001. Her report described a prison that had lost direction and was stalling. The follow up inspection in May 2003 showed that senior managers had identified the problems and taken effective action to stop, and reverse, the drift. Given the pressures that they were under, and in particular the fact that a third of the prison’s population were now remand prisoners, this was considered no mean feat.

7. There had been five previous deaths at Elmley since April 2004: one apparently self-inflicted, one as yet unclassified and three from apparently natural causes. The reports of my investigations into those deaths do not reflect issues similar to those identified in this report.

Events prior to the man's death

8. The man was remanded into custody by Maidstone Magistrates' Court on 29 October 2005 for an offence of common assault. He was initially taken to HMP Chelmsford. During the reception process, the man told staff that he was bi-polar and he had taken an overdose of his prescribed medication two days previously. He said that he had been kept in hospital for 24 hours, and that he had taken the tablets as he was going through a bad time over a family breakdown.

9. The man denied having any further self-harm or suicidal thoughts. Although the First Reception Health screen form was marked up for a F2052SH self-harm monitoring form to be opened, this was not done. The man's medical record shows that he said that he was not feeling suicidal, but there is no documented reason for the decision not to open the F2052SH. In answer to the question, 'have you ever tried to harm yourself?' both the 'No' and 'Yes outside prison' boxes have been ticked. The 'No' tick is an obvious error as further information about the man's reported overdose is written in the next box. It should also be noted that the health screening form was not signed by the member of staff who completed it. The man said that he abused heroin, cocaine and cannabis, but he was not displaying any signs of withdrawing from these drugs and it was decided to offer him symptomatic relief rather than a detoxification regime.

10. The man appeared at Sittingbourne Magistrates' Court on 31 October when he was further remanded in custody until 7 November.

11. He remained in a police cell because of prison overcrowding until 1 November when he was taken to HMP Peterborough. During the prison's reception procedure the nurse decided to open an F2052SH form. The man told the nurse that he had overdosed due to feeling low during detoxing. The man still maintained that he did not currently have any thoughts of harming himself. It was decided that he should be kept on normal location and checked three times a day, after each medication round and once during the night.

12. The man's case was reviewed the next day. It was recorded that he seemed a little unsettled during the review. The man admitted to trying to take an overdose the previous week, but did not give a reason for his actions. He said that he was comfortable at Peterborough and that he had been in contact with his family. He said that he had no thoughts of self-harm and that he had commenced his detoxification that day which helped. The observation level remained the same after the review and the man was advised that he could access the Listeners/Samaritans scheme if he wished, as well as talk to staff and/or family and friends.

13. The man returned to Sittingbourne Magistrates' Court on 7 November and was again remanded into custody until 5 December. On this

occasion, the man was taken to HMP Elmley. During Elmley's reception procedure, a Cell Sharing Risk Assessment form was completed. As on previous occasions, the man was assessed as a medium risk. It was noted that the man said he suffered from bi-polar disorder and that he would prefer a single cell due to his medical condition and medication. It was decided that the man should be located in a shared cell, which is a very common decision for prisoners on an open F2052SH.

14. Accordingly, the man was placed into a triple cell with two other prisoners.

Events surrounding the man's death

15. On 8 November, the man went to exercise in the morning and it was noted that he was joking with one of his cell mates. The man told an orderly that he wanted to see a doctor. Although he was not on the doctor's list, the prison doctor agreed to see him that morning. He recorded that the man was asthmatic and had not had his seretide 250 inhaler in Chelmsford (the Prescription Record shows that he was issued the inhaler on 30 October for in-possession use). It was also noted that he had recently had a cough. It was further recorded that the man had recently overdosed, but that he was not feeling depressed or suicidal at present. It was decided to continue with his present medication for his asthma and his bi-polar condition and to add amoxicillin 250 for his cough. The man was later issued with a salbutamol inhaler and the amoxicillin, but the seretide inhaler was not in stock. The entry noted that the man had been referred for a mental health assessment.

16. The man told the doctor that his seretide inhaler had run out the previous day. Seretide inhalers were not kept in stock but an order was faxed to the pharmacy at HMP Rochester. The prison doctor was told after the man's death that the box from Rochester had arrived late and it was not possible due to staff shortages to dispense the seretide inhaler that night. My investigator confirmed with the healthcare manager, that seretide inhalers were not kept in stock at that time. However, since the man's death, the inhalers are now a stock item. The healthcare manager told my investigator that any medication arriving late would be put to one side in healthcare to be dispensed the next morning. He also said that no entry would have been made on the patient's medical record. There was no real way for the night duty nurse to know that any patient had outstanding medication.

17. At 5.15 pm, the man collected his medication. It was noted that he seemed quiet but did not express any concerns. As part of his F2052SH observations, the man was seen at 7.45 pm when the entry notes that he was watching television and had no problems. It was again recorded that he was watching television at 8.45 pm, 10.15 pm and 11.30 pm. According to one of the man's cell mate's, the man was complaining of being short of breath a couple of hours after dinner, but he did not ring his cell bell or speak to staff about it.

18. At 1 am on 9 November, the cell bell was pressed to summon the Night Patrol Officer Support Grade (OSG). It is not clear which of the three occupants pressed the bell. However, it was answered by two OSG's, who went to the cell. The first OSG spoke to the man and asked what the problem was. The man said that he was having trouble breathing. The second OSG then took over and the man told him that his inhaler was working, but not seeming to have any effect. He asked to see the doctor. As there is no doctor routinely available

at the prison overnight, the second OSG said that he would speak to the nurse and let the man know what she said.

19. The second OSG rang a nurse in Healthcare. He explained the situation and added that the man was talking well with no breaks in his speech. During interview, the second OSG said that he has seen people having asthma attacks before. The man was talking normally and, if he had not told him he was having trouble breathing, the second OSG would not have been able to tell. The nurse in healthcare asked if the man could wait until the morning to see the doctor. She also said that she was not allowed to administer any medication other than the pump that he had already.

20. The second OSG returned to the man's cell and told him that the nurse could not give him any other drugs; but that she would come over if he got any worse. He also told the man that he had been scheduled to see the doctor in the morning. The man said that he would be alright as long as he got to see someone in the morning. The man then went back to his bed.

21. The man was checked at 2.30 am and it was noted in the F2052SH that he appeared asleep. He was checked again at 4.45 am when it was recorded that he appeared asleep on his back.

22. Shortly before 5.15 am, the man woke one of his cell mates. The man was now breathing heavily and standing by the window to try to get more air. The other cell mate also awoke. Although they cannot be sure, it was probably the second of the man's cellmates who pressed the cell bell at 5.15 am. The first of the man's cellmates was standing behind the man rubbing his back to try to help with his breathing.

23. The OSGs responded to the cell bell and saw that the man was now having more obvious difficulties with his breathing. The first of the man's cell mates asked for a doctor to be called to see the man. The second OSG told them that he would contact the nurse again, which he did. He explained that the man was now in more obvious distress and the nurse advised him to get 'Oscar one'. Oscar one is the prison radio call sign for the Night Orderly Officer, the person in charge of the prison during the night time. A senior officer was 'Oscar one' that night.

24. The second OSG contacted the control room at 5.21 am and asked for 'Oscar one' to ring him. The senior officer was in the process of unlocking the prison ready for the day shift. He received the message when he was en route to House block 3. The message asked him to ring House block 1, but did not indicate any particular urgency.

25. The nurse said in her interview that, when she was called by the second OSG shortly after 5.15 am, she said to him, 'Get Oscar one immediately and then I will be there'. The second OSG remembers

her response as, ‘Get Oscar one to have a chat with him or to get me’. The senior officer says that when he spoke to the second OSG there was no sense of urgency. He recalls the conversation as the second OSG saying that the nurse had said that when Oscar one came onto House block 1, he should look at the man and, if necessary, take him to Healthcare.

26. The nurse from healthcare said that, after the call from the second OSG, she rushed to fetch her green first aid bag, put the oxygen on her back and waited by the door. In her interview, the healthcare OSG did not recall the nurse waiting by the door. She said that she was unaware of any problem requiring the nurse to attend a house block until the nurse was collected shortly before 6.00 am. For security reasons, during the night the nurse is locked inside the Healthcare block and the OSGs are locked inside the various House blocks. Neither the nurse not the OSGs have keys. The Night Orderly Officer, Oscar one, is the only member of staff with full access around the prison, although the OSGs have a sealed pouch which in emergency circumstances enables them to unlock a cell. The second OSG said that, under these particular circumstances with three men in the cell, he would not have used his emergency key unless other officers had been present.

27. The man’s cell mates rang the cell bell several more times as they were getting very concerned for his health. Each time they were told that the nurse was on the way.

28. About 5.45 am, the senior officer arrived on House block 1 and, after speaking to the OSG’s, went up to the man’s cell. He looked into the cell through the door flap and saw one man (the second prisoner) apparently asleep on his bed, another (the first prisoner) sitting on his bed and a third (the man) lying on his front on his bed. The senior officer asked the first prisoner if the person lying on his bed was the man and, when that was confirmed, asked if he could wake up. The first prisoner said that he did not think that he could. The first prisoner says that at that point he told the senior officer that he believed the man to be dead. The senior officer has no recollection of being told that. The senior officer asked if he thought the man would be able to walk to Healthcare. Upon being told no, he said, ‘That’s not a problem. I will get the nurse to come up and see him.’ The senior officer said in interview that he did not enter the cell at that time as he believed the man to be asleep and he would have woken him. He added that, if he had found him collapsed, then he would not have been able to help him as he was not certified in first aid or confident to administer any. He believed that the best course of action was to get the nurse to the man’s cell as soon as possible.

29. The senior officer arranged for one of his staff to collect the nurse and bring her to House block 1. When the nurse from healthcare arrived at approximately 5.55 am she was taken straight to the man’s cell.

The senior officer opened the cell and entered with the nurse. The two other prisoners were taken out of the cell and put into separate cells in the segregation unit. They were kept in separate cells at the request of the police.

30. The senior officer and the nurse found the man lying on his left side face down on the bed. They turned the man onto his back and the nurse from healthcare saw immediately that he was not breathing. She put the oxygen mask onto the man and checked his pulse and blood pressure, but found no signs of either. She attached a machine to register the amount of oxygen in his blood and saw that none registered. The senior officer contacted the control room to call an ambulance and the nurse from healthcare began Cardio Pulmonary Resuscitation (CPR). The nurse noted that the man's mouth was blue and that he was warm. As CPR was continued, a slight increase in oxygen levels was noted on the machine. The ambulance arrived at 6.12 am and the crew took over CPR, but decided that their efforts were having no positive results. The man was pronounced dead at 6.21 am.

Events after the man's death

31. The man's mother was visited by the prison chaplain, who told her of her son's death. His family were not aware that he had been in prison. Subsequently, the prison has made a contribution towards the cost of the man's funeral.

32. The staff involved were not asked to take part in any kind of de-brief, although all were later interviewed by the police. The staff concerned work permanent 'night' shifts and are therefore not readily available during the day.

33. The investigating police officers found two salbutamol inhalers in the man's cell during their search. Salbutamol is designed to be used during an asthma attack, while seretide is used to help prevent an attack. Seretide had been prescribed for the man, but he died before the prescription could be filled and issued.

34. One of the concerns that the man's family expressed to my investigator was the apparent bruising on his chest and face when they saw his body at the mortuary. My investigator has been informed that the most likely cause of the discolouration is post mortem hypostasis, caused by the cessation of blood flow and its pooling at the lowest points. This is mentioned by the pathologist in the 'external examination' section of his report.

35. The post mortem examiner recorded that death was by natural causes. The cause of death was given as acute asthma.

Clinical review

36. Swale PCT agreed to carry out a clinical review into the healthcare that the man received whilst in custody in accordance with NHS policy. A doctor was asked to provide the report. His report was received by my office on 24 April 2006 some five months after the man death. It failed to address the following issues.

    - Quality of medical care the man received
    - Suitability of medication
    - Response to the medical call
    - Management of the man's asthmatic condition.

37. A second clinical review has now been carried out. The second clinical reviewer is critical of the lack of arrangements for the issue of prescribed medication arriving after normal dispensing times. He also thinks that it was an error of judgement by the nurse from healthcare not to ask for the man to be brought to healthcare at 1.00 am. The clinical reviewer further states that, in his opinion, her response to the clinical emergency on finding the man blue, collapsed and not breathing fell below an acceptable professional standard.

38. The second clinical reviewer writes that an alternative to the out of stock seretide would have been a prescription of the two components of the drug, serevent and flixotide. I have checked with Elmley and confirmed that neither of those drugs was a stock item and therefore would not have been available.

39. The clinical reviewer makes five recommendations in his report and I commend them to the Governor and his healthcare team.

40. **Healthcare staff should be reminded that asthma can be a serious and life-threatening condition. Many prisoners will allege they are asthmatic because salbutamol, which is the most commonly prescribed drug for asthma, is recognised to have what some people interpret as a stimulant action. Objective clinical assessment by medical and nursing staff following agreed and robust protocols is essential for prisoners who declare themselves to suffer from the condition.**

41. **A care plan should be prepared for the management and supervision of confirmed chronic asthmatics in the custodial environment, including the management of acute asthmatic attacks. Procedures and protocols must be known and understood by all staff in the event of a prisoner declaring himself to have deteriorating asthma night or day.**

42. **If there is any concern about the medical condition of any inmate, then full use of Healthcare in-patient facilities must be made with readily accessible support and back-up to nurses and**

other staff by duty on-call Medical Officers and Out of Hours services.

43. **Basic first aid trained officers should be available on House Block, especially at night, and all staff should receive regular training in Cardio-Pulmonary resuscitation.**

44. **The night time protocols for both prison officers and healthcare staff should be examined regarding their response to prisoners complaining of illness, and any required changes implemented.**

Findings and conclusions

45. A replacement Seretide inhaler had been prescribed by the prison doctor that morning but it was not an item that was kept in stock in the pharmacy. The inhaler was ordered from the pharmacy at nearby HMP Rochester but it arrived too late to be dispensed in the usual manner. It was put to one side to be dispensed the next day. There was no record of the item's arrival or its location on either the medical record. The nurse from healthcare had not read the medical record and was therefore unaware that the item had been prescribed.

The Governor, in conjunction with the Healthcare Manager, should ensure that there is a clear and robust procedure for recording the arrival and storage location of any prescribed medication waiting to be dispensed.

46. The security procedures in place in prisons overnight are very different to those that operate during the day. Only one officer (the senior officer, the Night Orderly Officer) could unlock the House blocks or Healthcare unit. (The OSGs on the individual House blocks have emergency sealed pouches containing a cell key.)

47. As usual, the nurse was locked in the Healthcare unit with a non-medically trained OSG. She was responsible for the health and welfare of all of the 17 patients in the Healthcare unit as well as being on call to any health related matter in the rest of the prison. Consequently, she had to make quick decisions about priorities.

48. There are procedures in place for movement around the prison at night by the nurse and for the unlocking of cells, but staff told my investigator that for practical reasons such events are limited as much as possible. That is not to say that, if the urgency of the situation in the man case had been properly conveyed, such procedures would not have immediately been implemented. My investigator is satisfied that nothing that transpired was done, or not done, out of malice or intentional neglect. Nevertheless, there was a lack of clear communication over the urgency of the situation.

49. None of the security staff who saw the man was current in their first aid training and none was qualified to make clinical judgements about the health of a prisoner. Nevertheless, at 1.00 am, when the second OSG first contacted Healthcare and spoke to the nurse from healthcare, he was asked for and gave her his opinion about the state of the man's health. She decided to accept the second OSG's opinion, knowing him to be an experienced colleague, and not attend at that stage. Believing that she was unable to give the man any other medication in any case, she scheduled him to be seen by the doctor in the morning.

50. The nurse from healthcare did not read the man's medical record nor did she decide to use the nebuliser which was available in the Healthcare unit. In her interview, she said that she decided not to use the nebuliser as the second OSG had told her that the man was going to use his inhaler.

51. The events that transpired after the 5.15 am cell bell call amount to poor communication between all parties. My investigator found that, notwithstanding the second OSG's years of experience, he viewed his role as one of intermediary, meaning that he would notify the relevant member of staff of an incident and then stand back.

52. The two OSGs were the only members of staff who were aware of the urgency of the situation. I believe that the second OSG, as the more experienced officer, should have followed up his initial call to the Night Orderly Officer in view of the length of time that passed before he arrived.

53. The nurse from healthcare believed that she conveyed the urgency with which she wanted to attend the House block, although she also did not contact the control room to ascertain the reason for the delay in her escort arriving. The second OSG believed that he conveyed the urgency of the situation to the senior officer, but the senior officer did not agree and said that he believed he had received a routine call rather than an emergency one.

54. When the senior officer eventually attended the man cell, his judgement was to get the healthcare nurse to the cell as quickly as possible. By his own estimate, that took almost ten minutes. If he had chosen to enter the cell, notwithstanding his lack of medical training, it is likely that he would have realised that the man was seriously unwell and would have called an ambulance sooner.

55. The second clinical review is critical of the nurse from healthcare's professional response to the clinical emergency when she arrived at the cell. He also said that the outcome would almost certainly not have been different, whatever the resuscitation skills of the nurse. The man died despite the efforts of staff and paramedics to save him.

56. My investigation has indicated that the delay in providing medical attention was the result of the implementation of the night time procedures and poor communication.

The Governor should review the procedures and protocols for the night patrol state and consider whether additional training for staff and/or changes to those procedures and protocols are required.

57. The man's cell mates were offered the appropriate support after his death, although it would appear that it is more difficult for the night staff to access post incident support.

58. It is regrettable that the staff did not have the opportunity to have a hot de-brief, as valuable insight into possible areas for improvement could have been gained. The reason for this omission would seem to be that all of the staff involved work a permanent night shift and it is therefore more difficult to attend a de-brief when senior managers are around. In the future, every effort should be made to arrange a de-brief.

The Governor should ensure that hot de-briefs are held after all significant events, day or night.

59. With the obvious difficulties in getting quick medical attention during the night time patrol state, I believe consideration should be given to providing first aid training for those 'front line' staff. This would be especially useful for those employed on permanent night shifts.

The Governor should consider providing first aid training for those staff working permanent night shifts.

60. A colour code system is employed at Elmley to indicate the nature of any medical emergency, although it was not used on this occasion.

The Governor should ensure that all staff are aware of the emergency colour code system and the protocols for its use.

61. Whilst there was no requirement to document certain decisions, such as the reason for not opening the F2052SH, I do consider it good practice and every effort should be made to do so. I have sent a copy of this report to the Governor at HMP Chelmsford for his information.

Recommendations

- **The Governor, in conjunction with the Healthcare Manager, should ensure that there is a clear and robust procedure for recording the arrival and storage location of any prescribed medication waiting to be dispensed.**

- **The Governor should review the procedures and protocols for the night patrol state and consider whether additional training for staff and/or changes to those procedures and protocols are required.**

- **The Governor should ensure that hot de-briefs are held after all significant events, day or night.**

- **The Governor should consider providing first aid training for those staff working permanent night shifts.**

- **The Governor should ensure that all staff are aware of the emergency colour code system and the protocols for its use.**

Recommendations from the Clinical Review

- **Healthcare staff should be reminded that asthma can be a serious and life-threatening condition. Many prisoners will allege they are asthmatic because salbutamol, which is the most commonly prescribed drug for asthma, is recognised to have what some people interpret as a stimulant action. Objective clinical assessment by medical and nursing staff following agreed and robust protocols is essential for prisoners who declare themselves to suffer from the condition.**

- **A care plan should be prepared for the management and supervision of confirmed chronic asthmatics in the custodial environment, including the management of acute asthmatic attacks. Procedures and protocols must be known and understood by all staff in the event of a prisoner declaring himself to have deteriorating asthma night or day.**

- **If there is any concern about the medical condition of any inmate, then full use of Healthcare in-patient facilities must be made with readily accessible support and back-up to nurses and other staff by duty on-call Medical Officers and Out of Hours services.**

- **Basic first aid trained officers should be available on House Block, especially at night, and all staff should receive regular training in Cardio-Pulmonary resuscitation.**

- **The night time protocols for both prison officers and healthcare staff should be examined regarding their response to prisoners complaining of illness, and any required changes implemented.**