

**Investigation into the circumstances surrounding the
death of a man, a prisoner at HMP Wayland,
In May 2010**

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

May 2011

This is the report of an investigation into the death of a man, a prisoner at HMP Wayland. He died in May 2010, having collapsed in the garden area of the prison where he was working. He was 57 years old. The cause of his death was found to be an acute dissecting aneurysm of the thoracic aorta. This is a tear in the wall of the heart which allows blood to flow between the layers of the vessel forcing them apart.

I offer my sincere sympathy and condolences to the man's family, and to all who have been affected by his loss. I apologise for the delay in issuing this report and any additional distress this may have caused.

The investigation was carried out by my colleague. A review of the man's medical care was led by a clinical reviewer, a lead nurse for Safeguarding Adults for NHS Norfolk. I am grateful to her for her assistance. I would also like to thank the residential governor for his work liaising with the investigator.

At the time of his death he had been in prison for almost 39 years. He had not been diagnosed with any significant health problems and his condition was an untreatable medical emergency which quickly led to his death. My report includes seven recommendations, these relate to communication with the emergency services, debriefing staff and breaking the news of a prisoner's death to their next of kin.

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.

Jane Webb
Acting Prisons and Probation Ombudsman

May 2011

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SUMMARY

The man was given a life sentence on 10 November 1971. During the early part of his sentence he was moved between prisons and hospitals for assessments of his mental health. He received diagnoses of psychotic illness, possible schizophrenia and high functioning autism. However, it was recorded that he responded well to settled environments. He arrived at Wayland on 12 November 2003.

He settled in well at Wayland and reportedly got on well with staff and fellow prisoners. Throughout his time at Wayland, he was largely unknown to the healthcare team.

On 21 May 2010 at approximately 9.10am, he collapsed in the market garden area of the prison where he worked each day. He was quickly attended by both healthcare and prison staff. The initial call to the emergency services was made at 9.15am but the ambulance only arrived 35 minutes later at 9.50am. The paramedics attempted to revive him but he was pronounced dead at 10.15am.

Several of the staff interviewed during the investigation expressed concern about the length of time which the ambulance took to arrive at the prison. The East of England Ambulance Trust indicated that the delay was due to the deployment of all local vehicles to other emergency calls. When the first 999 call was made the man was conscious, alert and breathing. The emergency services were updated 12 minutes later when his condition deteriorated and he became unresponsive. At this point the nearest available ambulance was approximately 30 minutes away from the prison at Downham Market.

Whilst earlier attendance by the emergency services may not have saved him, the clinical review panel recommends that prison staff telephoning the emergency services provide updates if the prisoner's condition changes.

Following his death, prison staff were initially unable to inform his family because the next of kin details in his prison file were out of date. Following extensive enquiries by the prison family liaison officer, contact was made with his brother.

This report contains seven recommendations which relate to communication with the emergency services, debriefing staff and breaking the news of a prisoner's death to their next of kin.

THE INVESTIGATION PROCESS

1. The investigation was opened on 31 May 2010 by the investigator and an Assistant Ombudsman. They were met by the liaison officer and reviewed the man's prison and medical files. Copies of documents from those files were given to my investigator. They both visited E wing and spoke to a prisoner who knew him and was with him when he collapsed on 31 May. The Ombudsman's terms of reference and notices of investigations were sent to the prison the following day.
2. During a further visit to Wayland on 7 June, the investigator met the Chair of the Independent Monitoring Board (IMB) and a representative of the Prison Officers' Association. She also spoke to two nurses from the healthcare unit who had attended to him and explained the investigation process to them.
3. The investigator and Assistant Ombudsman visited the prison on 21 and 29 June and interviewed six members of staff. A clinical review panel was arranged by the clinical reviewer, a lead nurse for safeguarding adults on behalf of NHS Norfolk. She met the investigator and Assistant Ombudsman on 29 June to discuss the medical care provided by the prison and to interview two prison nurses. Following this meeting a clinical review report was written. The review was received on 21 November 2010.
4. The man had not been in contact with his brothers and sister for several years. However, following extensive enquiries by the prison's liaison officer, contact was made with one of his brothers. The Ombudsman's family liaison officer wrote to the brother on 6 July to inform him of the investigation and ask whether he had any issues which he wished to be addressed. She later spoke to him, who said that, as far as he was aware, his brother seemed to have been treated fairly well at Wayland and appeared to have been well liked by both staff and prisoners. He had no issues to raise about the care which his brother received. He said that he was interested to receive a copy of the report when available. I hope that the findings of my report help to address any questions which the family may have about the circumstances of his death.
5. My report was issued in draft to the family and to the National Offender Management Service (NOMS). The family made a number of comments in response to the draft and these are included on page 19 of this report. NOMS' responses to my recommendations are also included at the end of this report.

HMP WAYLAND

6. HMP Wayland is a category C adult male prison¹ with a maximum operational capacity of 1017 across 13 wings. Four of the wings are for enhanced prisoners. The man lived in a single cell on E wing, the enhanced lifers unit. The regime provides a range of workshops and training facilities, including a Farms and Gardens area. The majority of the produce grown by prisoners is used in the prison kitchen. Wayland has achieved High Performing Prison² status for the last four years.
7. Healthcare at Wayland is commissioned by NHS Norfolk and provided by NHS Norfolk Community Health and Care who employ a healthcare manager, nurses and support staff. The service is provided between 8.00am and 8.30pm Monday to Thursday and from 8.00am to 5.30pm on a Friday, Saturday and Sunday. From October 1 2010, an integrated healthcare service has been provided by SERCO Health.³
8. Wayland was last inspected by HM Chief Inspector of Prisons in April 2009. She found that the current population of Wayland had nearly doubled since her last inspection. This had placed considerable pressure on the prison. Some areas, particularly reception and healthcare, were now struggling to cope with the numbers of prisoners that had to be dealt with. However, she commented that the managers and staff deserved credit for “managing the expansion in a way that ensured that Wayland remained a largely safe and purposeful prison, with a sound focus on resettlement”.
9. In their annual report for 2008, the Independent Monitoring Board⁴ made the following comments about healthcare:

“Looking back at last year’s report it is evident that healthcare provision at Wayland has moved forward with many of the points raised as concerns last year addressed. The management and staff work hard in what can be a difficult environment to deliver a good service and we thank them for their effort.”
10. This is the fourth death of a prisoner at Wayland since the Ombudsman began investigating all deaths in custody in England and Wales in 2004. All of the previous deaths were due to natural causes. My most recent report, regarding

¹ There are four security categories for adult male prisoners. Prisoners who are categorised as Category C cannot be trusted in open conditions but do not have the resources or will to make a determined escape attempt.

² Prisons are rated by HM Prison Service on a performance scale which takes account of the prison’s performance against a number of targets, the findings of external inspections and the prison’s compliance with policies.

³ Serco Health supports the National Health Service by working in long-term partnerships to deliver and support primary and acute care services.

⁴ The Independent Monitoring Board is a body of local people who independently monitor and report on the prison to ensure standards of decency and care are maintained.

the death of a man who died following a heart attack, included a recommendation that any episodes of chest pain are addressed as a matter of urgency.

KEY FINDINGS

11. On 10 November 1971, the man was convicted of a serious offence and sentenced to life imprisonment. He was then 18 years of age. He remained in prison or secure hospital for the remainder of his life. Early in his sentence he was moved to HMP Parkhurst as a result of his unacceptable behaviour. In 1977 he was transferred to Rampton Hospital for further assessments. He was assessed as having an IQ of 76, a result which indicates borderline normal intellectual functioning.
12. In 1985 he spent a further period in Rampton Hospital because he had displayed symptoms of paranoia. It was concluded that, although he showed paranoid traits when he was under stress, there was no further benefit to be gained if he remained in hospital.
13. He spent the next ten years in prison custody before, in 1995, concerns about his mental health led to him spending a short time in the Reaside Clinic. After three months of treatment he was returned to prison custody at HMP Frankland. He moved to HMP Wayland in 2003. He did not raise any concerns during his first reception health assessment. He adjusted well to life at Wayland and neither his medical or prison records show any significant events at this prison until late 2007.
14. He was assessed by the Parole Board⁵ on 17 December 2007. The panel requested a psychiatric report and the attendance of a psychiatrist at his next parole hearing which was due to take place in July 2008. For the purpose of this assessment he met a consultant forensic psychiatrist for people with learning disabilities at Wayland on 6 March 2008. The psychiatrist described him as having “a history of paranoid schizophrenia for which he was treated with antipsychotic medication”. The doctor noted that in recent years he had refused to take medication for his condition. He said that, whilst he appeared to be suffering from a borderline learning disability, he was not suitable for a medium secure unit specifically designed for people with learning disabilities. However, the psychiatrist suggested that he should be referred to the Reaside Clinic for further assessment and advice.
15. He was examined by a specialist registrar at the Reaside Clinic on 16 June. During this assessment he told the registrar that he felt he had served a long enough sentence and was ready to be in the community. He also said he had been admitted into secure hospitals because he had “faked symptoms” in order to get out of prison. In his written assessment, the registrar said that he was of the opinion that he was not suffering from a mental illness which would warrant a move to a secure hospital. He said he did not have any symptoms which were suggestive of any mood or psychotic disturbance. For this reason he concluded that he did not meet the Reaside Clinic’s admission criteria.

⁵ The Parole Board is an independent body that works within the criminal justice system to protect the public by risk assessing prisoners to decide whether they can be safely released into the community.

16. The man's last parole hearing took place on 17 September 2009. The Parole Board considered all the documents before it, including evidence from a consultant forensic psychiatrist and the prison psychologist. The panel did not recommend that he should be either released from custody or moved to open conditions.

21 May 2010

17. On the morning of 21 May 2010, he went to work as usual in Greenhouse 1 of the E wing market garden. He walked from E wing with another prisoner. The prisoner said they were due to start work at 9.00am. He told my investigator that he was his closest friend on the wing and they worked together every day. He said that during the short walk from the wing to the market garden, he had chatted happily and was in good spirits.

18. The prisoner told my investigator that when they arrived at the E wing market garden the man complained of feeling unwell. He approached the Market Gardens Instructor on duty and asked if he had a minute. However, because he was dealing with another prisoner, the Instructor was unable to come over immediately.

19. During his interview with my investigator, the Instructor explained that, when he was initially approached by the prisoner, he did not make it clear that the man was unwell. He said that he was routinely approached by prisoners asking if he had time to assist them. The prisoner went on to say that the man told him that he had pains in his chest and so he approached the Instructor again. On this occasion he told the Instructor that the man was unwell and he (the Instructor) immediately came over.

20. When he arrived in Greenhouse 1, the man was sitting on the floor complaining of pain in the right side of his chest. He used his radio to contact the control room with a 'code blue'⁶ for healthcare to attend. The control room log lists this call as being made at 9.10am. The Instructor, who is trained in first aid, said that whilst he was waiting for staff to arrive, he asked him a few questions about how he felt. He moved him into a more comfortable position and put a coat over him to keep him warm. He told my investigator that healthcare staff arrived very quickly. He remembered that one of the nurses was particularly out of breath when she arrived because she had been running with the emergency bag on her back.

21. Having heard the code blue call over their radios, two officers ran from E wing to Greenhouse 1. They found that the man was still conscious and talking to the Instructor and the prisoner.

⁶ A 'code blue' is called when there is a medical emergency. This indicates to staff that the patient is experiencing breathing or respiratory difficulties

22. The code blue radio message was heard by Nurse A, who for that day was acting as Hotel 1⁷ and was based in the healthcare centre. She told my investigator that she received the initial code blue call from the control room at approximately 9.10am. Because she was attending to another patient she asked Nurse B to respond. A few moments later, having left her patient in the care of another colleague, Nurse A followed the other nurse to the market gardens, taking the defibrillator⁸ with her. The control room log lists that healthcare staff arrived on the scene at 9.15am.
23. Nurse B told my investigator that she was working in the records room within the healthcare centre when her colleague, Nurse A, told her that a code blue had been called in the E wing market garden. She ran to the market gardens carrying the emergency bag, a journey that took three to four minutes. Anticipating her route to the gardens, some members of staff unlocked gates that she would need to pass through to ensure she was not delayed.
24. The man was conscious and responded when she arrived in Greenhouse 1. She took his blood pressure and carried out some basic clinical observations of his pulse, blood pressure and breathing. They were all normal and did not give her any cause for concern. He was fully conscious, alert and orientated. He was able to talk in sentences and no breathlessness was noted. He was described as having a good colour and he was able to confirm that he had no previous medical history and was not taking any medication.
25. Within a few minutes of the nurse's arrival, he appeared to have a seizure. She asked for an ambulance to be called and Officer A used his radio to ask the control room to request one. The control room log lists that the first call for an ambulance was made at 9.15am.
26. During the seizure his oxygen levels began to fall so he was placed into the recovery position. He stopped breathing and so both nurses, together with Officer B moved him onto his back and the two nurses began to carry out cardio pulmonary resuscitation (CPR). Defibrillator pads were positioned on his chest but the machine was unable to detect a shockable rhythm. The nurses requested an alternative defibrillator as a double check that no rhythm could be found but unfortunately it could not detect a heart rhythm.
27. Officer A said that he was not given an estimated time of arrival for the ambulance. He told the investigator that both he and Officer B contacted the control room for an update and were told that it was on its way. The control room log shows that three further calls were made to the emergency services at 9.25am, 9.40am and 9.49am.
28. Nurse B said that she and Nurse A continued CPR until the emergency services arrived and continued whilst the paramedics carried out their own advanced life

⁷ Hotel 1 is the member of healthcare staff responsible for responding to any medical emergencies in the prison on that day.

⁸ A defibrillator is a machine used to shock the patient's heart and restore the heart's normal rhythmic patterns. It cannot however, restart the heart if a detectable rhythm cannot be found.

support checks. The ambulance arrived at 9.50am, some 35 minutes after the first request was made. The paramedics immediately started advanced life support but were unsuccessful. He was pronounced dead at 10.15am. Nurse B told the investigator that the prison doctor also attended the incident.

29. Following his death a hot debrief⁹ was held by a residential governor which was attended by uniformed and healthcare staff. Staff were offered access to the prison's staff care and welfare team. Nurse B told the investigator that healthcare staff did not hold their own debrief into his death.
30. The governor spoke to the prisoner and told him that the man had died. He arranged for the other prisoners on the wing to go to the Chapel where they were informed of the death. All the prisoners were offered support from staff and access to a Listener.¹⁰ The prisoner made a request to attend the funeral but this was declined because he was not a relative. A memorial service was held for prisoners in the Chapel. The governor told my investigator that prisoners donated to a collection to purchase a bench in the man's memory.
31. The man's prison record listed his parents as his next of kin. On 27 May, some six days after his death, the governor contacted West Midlands Police and asked them to visit the address listed. Having visited the address, the police established that his parents no longer lived there. On the same day the governor emailed the man's prison probation officer to ask if she had any information regarding his next of kin. In her response she told him that his parents had passed away in the 1980s. She was aware that he had two older brothers and a sister but he had not had any contact with them since 1985.
32. On 28 May, the governor made further enquiries with the man's solicitors and the Salvation Army. Unfortunately, they were unable to provide any assistance. He also made enquiries with Birmingham City Council.
33. Three days later, on 31 May, he right arranged for the man's stored property to be returned from the National Property Store at Branston. It arrived at Wayland approximately two weeks later. He right told the investigator that, due to the length of time that he had been in prison, his property contained a large amount of documentation, including letters from his family. He found a letter in the property which had been sent by his brother. The letter also included a telephone number.
34. The governor made several unsuccessful attempts on 23 June to contact the man's brother by telephone. He also sent a recorded delivery letter asking the brother to contact him. On 29 June, he contacted South Wales Police and asked them to visit the address. However, before a police officer was able to do so, the brother contacted him by telephone.

⁹ A hot debrief should be held as soon as possible after the incident. The purpose of the hot debrief is to allow those involved to discuss any issues or concerns. The hot debrief should focus on reassurance, information sharing and how staff can support each other.

¹⁰ Listeners are prisoners who provide confidential emotional support to other prisoners.

35. The man's brother visited Wayland on 15 July. The funeral was held the following day. My investigator found that the prison's contribution to the funeral costs was in accordance with Prison Service Order (PSO) 2710.¹¹

¹¹ PSO 2710 provides instructions on the action to be taken following a death in custody.

ISSUES

36. The man arrived at Wayland in 2003. He was given the appropriate health assessments at which he did not raise any concerns. He was a heavy smoker and was given smoking cessation advice. In 2008 at the recommendation of the Parole Board, he was assessed to determine his suitability for a move to a medium secure unit. Whilst he appeared to be suffering from a borderline learning disability the assessment concluded that he was not suffering from a mental illness which would warrant a move to a secure unit.
37. No other medical concerns were reported and he showed no symptoms of a heart condition.

Response following the man's collapse

38. The clinical review panel found that there was a speedy and coordinated response by both healthcare and prison staff following his collapse. The staff who attended to him all understood the code system in response to a medical emergency. Both nurses gave a detailed account of their daily routine for checking medical equipment, in particular the contents of the emergency bags. Following his collapse the E wing staff ensured that the ground floor gate was opened. This meant that Nurse B's route to the market garden area was not obstructed. The actions ensured that she was able to reach him quickly.
39. The post mortem investigation concluded that he died from an acute dissecting aneurysm of the thoracic aorta. The clinical reviewer describes this as an 'untreatable medical emergency which will quickly lead to death'. Sadly, despite the timely efforts of staff, his condition was such that it would not have been possible to save him following his collapse.
40. Nurse A was acting as Hotel 1 on the morning of the man's death was also responsible for the healthcare clinic. When the code blue call was made she had a patient in attendance and was therefore unable to attend the emergency. In this particular instance she was able to call for assistance from another colleague who was able to attend. However, it is vital that the member of staff carrying out the role of Hotel 1 is able to immediately respond to a code blue alert. I therefore make the following recommendation:

Healthcare staff rotas should be managed so that those attending to healthcare emergencies are available and their duties can easily be covered in the event of an emergency.

41. The clinical review panel comments that a doctor is on site at Wayland between 8.30am and 12.30pm and 1.30pm to 4.00pm from Monday to Friday. The doctor is not routinely called upon to attend code blue alerts. In this instance the doctor was alerted approximately 40 minutes after the initial code blue call was made and arrived at Greenhouse 1 at the same time as the emergency paramedics.
42. The clinical review panel also comments that:

“... earlier attendance by the GP would not have made a difference to the outcome for him. However, in this instance it could have prevented the ongoing futile resuscitation of him as the GP may have been able to call death earlier.”

I make the following recommendation:

The Governor and Head of Healthcare should consider whether emergency response protocols should include the prison doctor when they are on duty at the prison.

43. The clinical review panel found that some of the healthcare staff who responded to his collapse felt traumatised by what they perceived as a lack of dignity for him as a patient. Prison Service Order 2710 says that, following a death in custody, all the relevant evidence must be preserved pending the arrival of the police. A member of staff must be posted to remain at the scene. He had received prolonged CPR in a very open area and these requirements meant that the surroundings could not be touched after he died. He remained where he died until the arrival of the undertakers. Healthcare staff were unable to attend to him, for example by covering him to protect his dignity, after he died. They had not been aware of the mandatory requirements and found them distressing.

All healthcare staff should be made aware of the mandatory processes to be followed after a death in custody.

44. The clinical review panel further comments that whilst a hot debrief was held in the prison, no debrief was held specifically for the healthcare team. This meant that learning opportunities were not pursued. All of the staff interviewed commented that they had been offered support by the prison’s Staff Care and Welfare team.

Following a death in custody a debrief should be held for healthcare staff with a focus on good practice and lessons learned.

45. A total of four calls were made to the emergency services by prison staff but the ambulance did not arrive until some 35 minutes after it was first requested. The clinical review panel comments:

“The East of England Ambulance Trust (EEAT) report indicated that there were no crews in the local area. One of the crews who were heading for the call had reportedly ignored the satellite navigation system as they believed they knew the way to the prison but instead took the wrong route. It is unclear if this added to the delay.”

46. The first 999 call made by staff in the prison’s control room indicated that the man was conscious, alert and breathing. Staff also informed the emergency services that healthcare staff who had access to a defibrillator were attending to him. For this reason he was assessed as requiring a lower priority response. The emergency services were not updated when his condition deteriorated until the second call was made approximately 12 minutes later. When the

ambulance trust were updated regarding his condition they once again deployed the nearest available ambulance which was approximately 30 minutes drive away at Downham Market. The clinical review panel comments that earlier attendance by the paramedic team would not have saved him.

All staff should be made aware of the need to update the emergency services if a prisoner's condition changes after the initial request for an ambulance has been made.

Breaking the news of the man's death to his next of kin

47. At the time of his death he had been in custody for 38 years. His parents passed away in the 1980s and he was not in contact with his brothers and sister. However, his parents were still listed in his prison records as his next of kin. This meant that following his death prison staff were unable to inform his family for several weeks and only after extensive enquiries by the governor. While I recognise the governor's efforts to locate the man's next of kin information I remain concerned that it took several weeks for the contact details of his brother to be identified within his prison records. I believe that a delay of this length is unacceptable.

The Governor should ensure that a prisoner's next of kin details are checked every year and are readily identifiable in a prisoner's records.

48. The prison rejected this recommendation. However, I believe it remains an important issue at Wayland and one that needs to be addressed. Personal officers could ask prisoners who they have responsibilities for to update their details on an annual basis.

49. There is specific guidance in Prison Service Order (PSO) 2710 (Follow up to Death in Custody) about how the news of a prisoner's death should be passed on to their next of kin. The PSO says that Governors must:

“Arrange notification to the next of kin and any other person reasonably nominated by the prisoner as soon as possible in a suitable manner, giving an accurate factual account of what has happened.”

50. The accompanying family liaison officer (FLO) guidance recommends that:

“The family should be informed face to face as soon as possible after the death. Wherever possible this should be done by a dedicated Family Liaison Officer working alongside the Chaplain, or Governor or most senior individual available together with the Chaplain.

“If distance from the prison presents a problem, a dedicated Family Liaison Officer or chaplain based in the area nearest the family home could inform the family face to face.

“The prison should demonstrate its duty of care and show that it is taking the death seriously by making a personal visit.”

51. The police were asked to visit the man's brother on 29 June. The governor told the investigator that the purpose of the police visit was not to break the news of his death but to confirm that his brother lived there. Before they were able to do so, his brother telephoned Wayland.
52. Given that the brother lives between two other prisons in Cardiff and Gloucester, I do not think it would have been unreasonable for staff at Wayland to have asked a member of their staff to visit and break the news of his brother's death.

The Governor should ensure that, wherever reasonable, the news of a death in custody is broken to the next of kin by an appropriately trained member of prison staff, face to face, in accordance with national instructions.

FAMILY RESPONSE TO THE DRAFT REPORT

53. I received several comments from the man's family on the draft report which I have discussed below. I hope that my comments help to clarify any outstanding issues that the family might have.
54. The man's brother expressed concern that the doctor should have attended the scene more quickly. He was also concerned about the length of time taken for the ambulance to arrive.
55. The clinical reviewer writes in the clinical review, "The GP is not routinely called upon to attend code blue alerts, in this instance he was alerted approximately 40 minutes after the initial call by the assistant Governor". She concludes that earlier attendance by the GP would not have made a difference to the outcome for him. However, she writes that earlier attendance by the GP "could have prevented the ongoing futile resuscitation of him, as the GP may have been able to call death earlier". I agree with her view. My second recommendation aims to address the issue of including prison doctors in emergency response protocols and was accepted by NOMS.
56. The first telephone call made to the emergency services indicated that he was conscious, alert and breathing. He was therefore assessed as requiring a lower priority response. The emergency services were not updated when his condition deteriorated. The clinical reviewer writes that, "delays in the response of the emergency services were due to deployment of all local vehicles to other emergency calls, and triage of available crews to a higher priority call". As I have previously noted, earlier attendance by the emergency services would not have saved him. However, after the initial request for an ambulance it made it is important that staff should update the emergency services if the patient's condition changes. My fifth recommendation aims to address this issue and again, was accepted by NOMS.
57. The family also commented that it had been distressing to learn that he had been left where he died for a prolonged period in order to preserve evidence. They felt this was undignified and inappropriate. The clinical reviewer writes in the clinical review:

"Healthcare staff responded quickly and effectively, however they found this incident traumatic due to what they perceived as a lack of dignity for the patient who had received prolonged CPR in a very open and public area. Furthermore they were unable to tend to him after death. They had not been aware that a prison death became a police incident and the location a restricted crime scene".

Whilst PSO 2710 advises that following a death in prison custody all relevant evidence must be preserved pending the arrival of the police, I recognise the distress that this caused healthcare staff and his family. My third recommendation addresses the issue that all healthcare staff should be made aware of the mandatory processes to be followed after a death in custody. This recommendation was also accepted by NOMS.

CONCLUSION

58. The man had been in custody for almost 39 years. Despite difficulties during the early part of his sentence, in recent years there had been a marked improvement in his behaviour. He had settled in well at Wayland and was popular with staff and prisoners. He appeared to be healthy and enjoyed working in the prison garden every day.
59. The clinical review panel has found that there was a speedy and co-ordinated response to his collapse by both the healthcare team and prison staff. However, there are some areas which they consider could be improved. In particular, the panel recommends that following a telephone call to the emergency services, staff should keep the relevant ambulance trust informed if the patient's condition changes.
60. His death was unexpected. His condition was an untreatable medical emergency which quickly leads to death. Unfortunately, his brother was only informed of his death several weeks later because the details of his next of kin were out of date.

RECOMMENDATIONS

1. Healthcare staff rotas should be managed so that those attending to healthcare emergencies are available and their duties can be easily covered in the event of an emergency.

Accepted- Healthcare staff identified for emergency responses will be informed that in the event of an emergency, to stop any current tasks/jobs handing over to a colleague and return to them once the crisis is over.

2. The Governor and Head of Healthcare should consider whether emergency response protocols should include the prison doctor whilst they are on duty at the prison.

Accepted- This is depending on the level of emergency but particularly in the event of any life threatening situation, the prison doctor will be requested to attend that emergency to support the patient and the healthcare staff in attendance prior to the arrival of the emergency response ambulance.

3. All healthcare staff should be made aware of the mandatory processes to be followed after a death in custody.

Accepted- This is currently within the local security strategy document regarding the preservation of evidence. All personnel at HMP Wayland, including healthcare staff, have been advised and made aware to access this information accordingly.

4. Following a death in custody a debrief should be held for healthcare staff with a focus on good practice and lessons learned.

Accepted- If any such incidents of this kind occur the clinical healthcare lead will activate a 'debriefing session' which will identify areas of concern and highlight any good practices. This will be recorded in writing along with action points arising if applicable.

5. All staff should be made aware of the need to update the emergency services if a prisoner's condition changes after the initial request for an ambulance has been made.

Accepted- This has been included within the establishment's first aid policy which is available to all staff.

6. The Governor should ensure that a prisoner's next of kin details are checked on every year and are readily identifiable within a prisoner's records.

Not accepted- HMP Wayland allows for all new receptions to have their emergency details checked upon reception, amended and updated accordingly. Current prisoners who have been at Wayland for any lengthy period are encouraged (via their personal officers) to make amends to their emergency details as necessary. Implementing this recommendation would result in a

disproportionate resource being used considering the frequency of deaths in custody occurring where no next of kin information is available.

7. The Governor should ensure that, whenever reasonable, the news of a death in custody is broken to the next of kin by an appropriately trained member of prison staff, face to face, in accordance with national instructions.

Accepted- Although the Governor still considers the course of action taken after the death of the man was appropriate considering the particular circumstances, where possible the establishment's family liaison officer will break the news of a death in custody face to face to the next of kin. In the event where a considerable travelling distance is likely then a more local establishment will be contacted in order to visit the family in the first instance prior to any invitations to the family to visit the establishment.