

**Investigation into the circumstances surrounding the death of
a man at HMP Wayland on 21 May 2004**

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

April 2005

This is the report of an investigation into the circumstances of the death of a life sentence prisoner at HMP Wayland. He died on 21 May 2004 in outside hospital following a stroke.

The investigation was led by one of my Senior Investigators. A clinical review into the man's care and treatment was commissioned from Southern Norfolk Primary Care Trust (PCT).

We would like to extend our condolences to the family for their loss. I would like to thank the Governor of HMP Wayland and his staff for their help.

This version, published on my website, has been amended to remove the names of the deceased, his family and those staff and prisoners involved in my investigation.

Stephen Shaw
Prisons and Probation Ombudsman

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Summary

The man died aged 57 at the Norfolk and Norwich University Hospital on 21 May 2004. He was taken there by ambulance from HMP Wayland on 19 May after being found in his cell unconscious but breathing. He subsequently died from a stroke. His death was not connected to the fact that he was in prison or to the level of care that he received there.

The man suffered a brain haemorrhage in 1998 and since that time had been placed on the International Subarachnoid Aneurysm Trial under the Radcliffe Hospital in Oxford. His condition meant that he was liable at any time to suffer a spontaneous and fatal rupture of blood vessels in his brain and there would be no prior warning.

The Governor and staff at HMP Wayland responded to his short illness and sudden death with professionalism and sensitivity to his family. Some care was taken to put out a further notice when it became apparent that the family were going to visit Wayland.

There are few recommendations arising from this investigation. The clinical review [not published] highlighted some procedural considerations for the dispensing and recording of medication.

Investigation process

My practice in investigations into a death from apparently natural causes is to conduct an initial review to determine the extent of investigation required.

My investigator visited HMP Wayland on 28 May 2004. She met the Governor who provided her with the man's prison record and copies of the notices, reports and other paperwork associated with his death. She visited the wing and cell where he had lived, and the Healthcare centre where she spoke to the clinical nurse manager and the prison doctor.

She also gathered details of the man's next of kin, the Coroner, the police liaison officer and the appropriate contact in the Southern Norfolk Primary Care Trust (PCT). One of my Family Liaison Officers subsequently contacted the family.

No formal interviews with staff were conducted. This report is based upon informal discussions with the Governor and staff at Wayland, a thorough review of all relevant paperwork and the findings of the clinical review.

Background

The man who died was a life sentence prisoner and had been in prison since 1989. He had been at Wayland since 6 September 2002 where he seemed to have settled well.

He had suffered a brain haemorrhage in 1998 leaving him vulnerable to a future fatal haemorrhage. He received medication for his condition and was tested regularly as part of a trial conducted by the Radcliffe Hospital. The trial took the form of filling in a questionnaire. He arrived at Wayland on this treatment and it was reviewed monthly, but not altered, during his time there. The most recent trial was in April 2004. The prison doctor told my investigator that he had completed the trial with the man and that he had not reported anything untoward. The doctor observed that the man's condition had meant that his death would be sudden and with no warning as he would suffer a spontaneous rupture.

On arrival at Wayland in September 2002 the man was passed 'labour three' which meant that he was deemed unfit for gym and heavy work. Despite his condition, he was not a regular visitor to healthcare. Most of the entries on his Inmate Medical Record (IMR) relate to his repeat prescriptions. In addition it is noted that he suffered from tendonitis in his wrist and smoked 25-30 cigarettes a day.

The clinical nurse manager told the investigator that the man liked to read and write. She said he was a polite man and always co-operated with healthcare staff. She felt that he found the mental slowness, which he had as a result of his previous stroke, frustrating. He had made friends at Wayland and attended the Introduction to Alcohol Awareness course in education. He was employed as the library orderly.

He had only limited contact with his brothers and sisters during his time in prison.

The Events of 19 - 21 May 2004

On 19 May 2004, the man attended the Introduction to Alcohol Awareness course between 2pm and 4.30pm. A fellow prisoner remembered walking back to the wing with him and laughing and joking about the next session. He said that the man was in good spirits and had not reported feeling unwell.

At about 4.50pm, an Officer reported that he was locking up the wing for tea time roll check. He said he saw the man lying on his bed and failed to get a response from him. He called another Officer who used his radio to summon medical assistance. The second Officer reported that the man was lying on his back with one leg rigid and his right arm in spasm. He said that he was breathing regularly but did not respond to any stimulus.

Shortly afterwards the doctor arrived at the cell with two healthcare officers. After a short examination, the doctor decided that the man had suffered a stroke and asked for an ambulance to be called. The ambulance was called immediately at 5.07pm. A further call was made at 5.25pm and staff were advised that the ambulance would be another 10 minutes. The ambulance arrived at 5.38pm and left at 6pm taking the man to Norfolk and Norwich University Hospital. While waiting for the ambulance, staff gave him oxygen and continued to monitor his condition.

Once at hospital, the man was intubated, ventilated and had a CT scan of his brain. The scan revealed a large left-sided intra cranial haematoma. The scan was discussed with the neurosurgical unit at Addenbrooke's Hospital and it was decided that this was not an event that he would survive. He was transferred to the Intensive Care Unit but showed no signs of neurological recovery.

On arrival at the hospital, the escorting staff rang the prison for advice on the use of handcuffs. The Governor advised that, for the preservation of dignity, these should not be used. The Governor told the investigator that he did not pursue an application for release on compassionate grounds because hospital staff advised him that death was imminent.

The man died on 21 May at 1.30pm. His family were present at the hospital and agreed that his kidneys could be used for donation. They were subsequently transplanted.

Level of Compliance with Prison Service Requirements

The decision to not use any form of handcuff or restraint was entirely appropriate given the circumstances. I think the Governor made the right decision, and commend him for it.

HMP Wayland followed its contingency plan relating to deaths of prisoners. Statements were taken from staff, the Independent Monitoring Board were informed and notices to staff and prisoners were put out. The post-incident response was fully compliant with Prison Service instructions and policies on managing a death in custody.

A further notice was put out in advance of a visit to the prison from the family. This is good practice and again the prison should be commended.

When my investigator arrived at Wayland, she found that all relevant information had been gathered together and sealed. Arrangements were made for the investigator to speak to relevant members of staff and the Governor personally escorted her around the prison.

The Family

The man had three brothers and a sister. He had not been in regular contact with them for some years. The Governor managed to contact two of his brothers on 19 May and they travelled to Norfolk that evening. They spent the next day in the hospital with their brother and on Friday 21 May they gave their permission for doctors to turn off his ventilator.

The brothers met the Governor at the prison on the afternoon of 21 May. They were offered the opportunity to walk around the grounds but did not want to. They collected the man's property and staff promised to deliver the remainder, which was in store at Branston.

One of my Family Liaison Officers, tried to contact the brothers on several occasions but it appears they did not wish to have contact with this office concerning the investigation.

Findings

The clinical review did not find any deficiencies in the man's medical treatment while at Wayland. It seems clear that he had a medical condition that was likely to become acute at any time and without warning. He was on regular medication and was monitored as part of a trial at the Radcliffe Hospital. His records indicate that he was otherwise in pretty good health and did not visit the healthcare centre regularly other than to collect his medication.

He seemed settled in Wayland, had made friends and was attending courses. I have seen no evidence to suggest that he had any other issues that were affecting his mental or physical health. On the day he died, the last person to see him remembers that he was laughing and joking and looking forward to the next session on his course.

Conclusion and Recommendations

There was no extra preventative action or treatment that would have caused the man to live longer. There was nothing that staff who found him and attended him in his cell on 19 May could have done to save his life.

The only recommendations that I make are taken from the clinical review:

1. Prisoners at HMP Wayland should sign for their medication on receipt from the dispensary.
2. The practice of recording medication monthly in the IMR should be reviewed since all prescribed medication is already recorded on the prescription chart.
3. A records audit should be undertaken to ensure that standards for record keeping are met.

Good Practice

The Governor put out notices to staff and prisoners on 21 May informing them of their fellow prisoner's death. The man's brothers were able to visit the Governor that afternoon. A further notice was put out in advance of this to staff and prisoners on the man's wing and the wing on which he attended his course. This explained the circumstances of the family visit and asked everyone to let the family party approach people if they wanted to rather than questioning them. I consider this to be good practice. It shows sensitivity to the family who would be in an unfamiliar environment at a difficult time and might not want to be approached.

I was also pleased to note the Governor's decision that there was no need to use handcuffs or any form of restraint when he was in hospital.

Earlier in this report, I have commended the Governor for both examples of good practice.