Investigation into the circumstances surrounding the death of a man in hospital in November 2008 whilst released on temporary licence from HMP Erlestoke

Report by the Prisons and Probation Ombudsman for England and Wales

October 2009

This is the report of an investigation into the death of a man who was 42 years old when he died in hospital in November 2008.

The man had suffered a brain haemorrhage after collapsing at HMP Erlestoke on 23 October. He was taken to hospital, before being transferred to Southampton for surgery. The prison kept an officer at the hospital until 31 October when the man was granted release on temporary licence. Sadly, the man did not recover and died two days later.

I would like to offer my sincere condolences to the man's family and to all those affected by his death. I understand that he was popular amongst his fellow prisoners and that a memorial service was well attended. I hope that this has provided some comfort to his family.

The investigation was carried out by two of my investigators. One of my Family Liaison Officers contacted the man's parents to discuss my investigation, and she and one of the investigators visited them at their request to discuss the questions they had about their son's death in greater detail. I have endeavoured to reflect the family's concerns in this report. The Family Liaison Officer has also been in contact with the man's wife from whom he had been estranged. The Family Liaison Officer passed on her concerns to the investigator and I have sought to address them as well.

A clinical review of the treatment which the man received in custody was commissioned by the local Primary Care Trust. The clinical reviewer's task was to assess whether the care that the man received in custody was comparable to that he would have received in the community. I am very grateful to the clinical reviewer for his assistance. A copy of his review is annexed to my report.

I would also like to express my thanks to the Governor and the staff and prisoners at Erlestoke for their full cooperation whilst my investigation took place. I especially thank the Deputy Governor, who liaised with my investigator and who organised the interviews conducted at Erlestoke.

The man had been in custody since 3 December 2007. Initially, he was held in HMP Lewes, before being transferred to Erlestoke on 11 July 2008. I endorse three recommendations made by the clinical reviewer. I highlight one example of good practice.

This version of my report, published on the Ombudsman's website, has been amended to remove the names of the man who died and those of staff and prisoners involved in my investigation.

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Prisons and Probation Ombudsman **October 2009**

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SUMMARY

The man arrived at HMP Lewes on 3 December 2007. He had been recalled to custody after committing a new offence whilst living in the community on licence. He had been misusing drugs and therefore underwent a controlled detoxification process. During a routine health assessment, the man's blood pressure was found to be high, but this was not monitored or reviewed again in Lewes.

The man underwent a scheduled operation on his knee at the start of April 2008. On 2 May, he received a fresh custodial sentence at Crown Court. In June, the man was observed to be under the influence of drugs and was found in possession of them. As a result he lost his job. Other benefits were also withdrawn under the Incentives and Earned Privileges (IEP) scheme. (This allows a prisoner to earn certain privileges in return for constructive behaviour. Similarly, privileges can be taken away if a prisoner does not comply.)

On 11 July 2008, the man transferred to HMP Erlestoke where he was located on Wren Unit for his induction. Later that month, he experienced headaches over a two week period. A doctor identified that the man's blood pressure was raised, and prescribed appropriate medication to lower it. Blood tests were also carried out, but the results did not indicate any reason for concern. The man wrote to his parents in early August, describing the prolonged headaches but indicating that they had stopped for the time being. A doctor had written in the man's medical record that his blood pressure was to be reviewed, but no further checks were carried out.

The man reported a further headache on 30 September. The nurse asked relevant questions and told him to ask to be assessed by a doctor if the pain continued. In early October, officers on the man's unit noticed that his mood was low and they ascribed his unhappiness to emotional stress. Soon after, the man moved to Alfred Unit.

During the night of 22 October 2008, the man developed a worsening pain in his head. Just after 7.00am on 23 October, he asked the night patrol officer if he could be examined by a member of the healthcare team. A staff nurse assessed the man at 9.25am on her morning rounds. He collapsed during the examination and staff placed him in the recovery position. An ambulance was called, and the man left Erlestoke for hospital just after 10.00am.

Upon arrival at the hospital, the man is believed to have suffered the significant bleed in his brain. Just after 11.00am, the escort chain was removed. Later that day, the man was transferred to another hospital where he underwent an operation later that evening. Further surgery followed on 24 October. His parents travelled to Southampton and stayed with him from 26 to 29 October.

The man was released from custody on temporary licence on 31 October, meaning that the escorting officer at the hospital was no longer required. He died two days later. The cause of death was a subarachnoid haemorrhage (a bleed in the man's brain) resulting from a ruptured aneurysm. This led to the blood vessels in his brain constricting in the days that followed, causing a reduced flow of blood to the brain.

The man's funeral took place on 19 November. A memorial service was also held in the prison.

My investigation has highlighted exemplary treatment of the man's parents by the management team at Erlestoke. He had named his parents as his next of kin. However, I am aware that the man's estranged wife felt excluded from events following his death. This is a problematic area and it can be hard to strike the right balance.

I have endorsed three recommendations made by the clinical reviewer.

THE INVESTIGATION PROCESS

1. My investigator was formally notified of the man's death on 3 November 2008. Notices were subsequently issued to both staff and prisoners at Erlestoke, informing them of the investigation process and giving them the opportunity to contact my investigator if they felt that they could assist in providing relevant information. Three prisoners came forward, and the investigator was able to speak with one who was still in custody. Two had already been released and, despite the best efforts of my investigator, could not be contacted.

2. The investigator spoke with the Deputy Governor at Erlestoke on 4 November. As the prison's liaison officer, he provided my investigator with all the records relating to the man's time in custody.

3. Having examined the relevant documents relating to the man's time in custody and the medical treatment he received, the investigator arranged to visit Erlestoke with another investigator on 4 December. He interviewed the Deputy Governor, the nurse who had been present when the man collapsed, and one of the prisoners who had asked to speak with him. The investigator returned to Erlestoke on 22 January and 3 February 2009 to interview two prison officers.

4. The investigator wrote to the local Coroner's office to inform them of the nature and scope of the investigation, and to request a copy of the post mortem report. HM Coroner will be provided with a copy of my report.

5. The investigator also contacted the local Primary Care Trust (PCT) and asked that a clinical review be carried out into the medical treatment that the man received in custody. The purpose of the review is to establish whether the care which he received was comparable with that he could have expected in the community. The clinical review is annexed to my report.

6. On 25 November, one of my Family Liaison Officers telephoned the man's parents, who were his listed next of kin. She discussed with them the questions and concerns they had regarding the circumstances surrounding their son's death. She then wrote to them, providing information about my investigation and acknowledging the concerns which had been highlighted during their conversation.

7. Both the Family Liaison Officer and the investigator visited the man's parents at their home on 8 December. This meeting provided the man's parents with the opportunity to discuss their concerns in more detail. I have addressed the issues raised during that visit in this report, which I hope gives the family a better understanding of the events leading up to his death.

8. Having been made aware that the man's wife had contacted staff at the prison, the Family Liaison Officer wrote to her to ensure that she was aware of my investigation. She and the man were estranged but were in relatively recent contact. I have also reflected the concerns which the man's wife raised in my report.

HMP ERLESTOKE

9. HMP Erlestoke is a category C closed training prison which holds adult male sentenced prisoners. The focus of activity is preparing prisoners for their release. The regime delivers programmes designed to address offending behaviour, and also provides education and training. Erlestoke has an operational capacity of 470 prisoners and comprises eight residential units. It is the only prison in Wiltshire and is situated near the towns of Devizes and Westbury.

10. Since my office took responsibility for investigating all deaths in prison custody in April 2004, I have investigated one other death at Erlestoke, also attributable to natural causes. My previous report made no formal recommendations.

11. The commissioning of healthcare within Erlestoke is the responsibility of the local Primary Care Trust (PCT). The prison does not have inpatient facilities. Prisoners who feel unwell are able to visit the doctor the following day if the matter is urgent, or otherwise they will be given an appointment within a week. If a prisoner wants to see a nurse on the same day, they have to submit a 'special sick' application by 8.00am.

12. Nursing staff are in attendance at Erlestoke between 8.00am and 4.30pm from Monday to Friday. Doctors are contracted from a local surgery, and hold a morning clinic each weekday for approximately an hour and a half, normally seeing between 12 and 14 patients. For the rest of the working day until 6.00pm, the local surgery is available to offer assistance and advice over the telephone.

13. Between 6.00pm and 8.00am on weekdays, and over the weekend, there are no members of the healthcare team on site. Prison staff who are concerned about a prisoner's health during these periods are required to call the local NHS out of hours service, which will help the officer to decide if either a doctor or an ambulance should be called. This is the same service that members of the public can access in the community. An out of hours doctor will attend from Trowbridge, about 20 minutes drive away. An ambulance would be dispatched from Salisbury. (Erlestoke's limited healthcare staffing is not unusual for a category C prison.)

14. During out of hours periods, there is a minimum of one member of prison staff who is first aid trained on the premises. This is usually the night orderly officer, who is a senior officer. They are based centrally within the prison with two other officers, and there is also an officer located in each residential unit.

15. An announced inspection of Erlestoke was conducted by Dame Anne Owers, HM Chief Inspector of Prisons, between 28 April and 2 May 2008. Following her inspection, Dame Anne criticised the condition of Wren Unit, and recommended its closure. She also commented on the prevalence of drug misuse within the prison. However, she praised the amount of purposeful

activity available to prisoners. With regard to the provision of out of hours healthcare, Dame Anne said:

> '… some prison staff were not aware that the out of hours service could be contacted to attend the establishment if required …'
>
> 'Although [the Inspectorate] contacted the PCT during the inspection to confirm the arrangements in the contract with the out of hours service, we were not provided with a copy of the relevant document.'

16. Dame Anne made a number of recommendations in her report, including the following:

> 'Resuscitation equipment should be easily accessible and available for use at all times …'
>
> 'The arrangements for contacting health professionals when health services staff are not on site (out of hours) should be made clear to all relevant staff.'

17. The most recent annual report published by the Independent Monitoring Board (IMB) at Erlestoke covers the year from 1 November 2006 to 31 October 2007. (The IMB at each prison is made up of members of the public who are both independent and unpaid. They monitor the day-to-day life in their local prison and ensure that proper standards of care and decency are maintained.) With regard to healthcare at Erlestoke, the IMB commented:

> 'The healthcare manager appointed early in 2007 has … successfully recruited a much stronger team … Staffing has improved out of all recognition.'
>
> 'The general healthcare provider, the local PCT, is quite supportive, although it knows little of prison life and has no other prison in its area with which to compare.'
>
> '… there are plans to introduce a number of clinics … on the accommodation wings.'
>
> '… Healthcare is in the process of moving from inadequate premises to a newly refurbished building … [something which has since happened].'

KEY FINDINGS

From 3 December 2007 until 11 July 2008

18. The man had been released on licence from HMP Ford on 5 October. He reoffended on 23 November, causing his recall into custody at the start of December. He arrived at HMP Lewes on 3 December. The man resumed serving his original custodial sentence (and would receive another prison sentence as a result of the newly committed offence in May 2008).

19. Upon arrival at Lewes, the man underwent a routine first night health screening. No significant issues were identified during this assessment, apart from the fact that he was due to undergo an operation on his knee. He reported a history of substance misuse. The man had misused class A drugs intravenously and he mentioned overdosing on heroin approximately five years earlier.

20. It was arranged for the man to begin a subutex and diazepam detoxification procedure. This was to allow him to safely withdraw from the heroin and benzodiazepines which he had been misusing in the community. (Subutex is a heroin substitute, and diazepam is a managed form of benzodiazepine). In the longer term, a period in a residential rehabilitation facility was also planned for the man upon his eventual release on licence.

21. During a secondary health assessment completed on 3 December, the man told staff that he smoked about 20 cigarettes each day. He reported a history of strokes within his family. He said that his father had suffered two strokes in recent years. The man's blood pressure was found to be high on 3 December, but no follow up check took place at Lewes. He had used crack cocaine shortly before entering custody, and it may be that healthcare staff associated his raised blood pressure with his drug misuse as there is a recognised link between the two. The treatment route pursued was therefore detoxification.

22. The man mentioned a history of reactive depression during his initial assessment, and a referral was therefore made to the mental health team. He was assessed on 6 December. No evidence of either a severe or enduring mental health problem was found, and for this reason it was thought there was no reason to offer further appointments. However, the man continued to meet with the Counselling, Assessment, Referral, Advice and Throughcare (CARAT) team, who work with prisoners who misuse drugs. The CARAT team felt the need to ask for another assessment of the man's mental health, and this took place on 8 January 2008. Once more, the mental health team did not feel that he required any further treatment, referral or assessment with regard to a serious mental illness. The man was prescribed 125mg daily of amitriptyline (an antidepressant medication used to treat low moods).

23. On 3 April, the man was admitted to hospital for a scheduled operation on his knee. A nurse had previously visited Lewes to assess him and prepare him

for the operation. It is not clear whether the man's blood pressure was taken at the time of his operation, or indeed whether it was raised at the time. Nonetheless, the operation was successful.

24. The man subsequently made a complaint on 5 April about the aftercare he received at the prison. He claimed that he had asked to see a doctor and had been told that he could not. He said that he was discharged from hospital with painkillers, but was subsequently refused them in the prison. The prison's response to the man's complaint stated that he had been prescribed co-codamol (a painkiller) following surgery for 24 hours. He saw a doctor the next day and was prescribed paracetamol.

25. The man appeared at Crown Court on 2 May. A new 42 month prison sentence was imposed in relation to the offence which he had committed whilst in the community on licence in November 2007.

26. Towards the end of June, the man was observed by prison staff to be under the influence of drugs. Having previously tested negative for drugs in April, he now tested positive for benzodiazepines and was found with them in his possession. As a result, he was placed on report (subject to disciplinary proceedings) and put on the basic regime under the Incentives and Earned Privileges (IEP) scheme. (The IEP scheme seeks to encourage and reward compliant and constructive behaviour by prisoners. Prisoners can either gain or lose certain privileges, depending on their actions. Basic is the lowest of the three levels of the scheme.) The man's job in the kitchen was also taken away. He had been the subject of several Security Information Reports during his time in custody which indicated that he and fellow prisoners might have forced others to hand over their prescribed medication.

From 11 July until 2 November

27. The man was transferred to Erlestoke on Friday 11 July. A cell sharing risk assessment was completed upon his arrival, during which he reported experiencing both mood swings and paranoia. An officer interviewed him and completed his induction onto Wren Unit. She found the man to be both polite and respectful. He did not report any problems or concerns to her.

28. On 12 July, the man's induction was completed. An officer ensured that he understood his entitlements and obligations as a prisoner and escorted him to the healthcare centre to collect his medication. He was prescribed six ibuprofen tablets on 12 July, and six paracetamol tablets on 13 July, but it is not clear from the medical notes precisely why the treatment was issued.

29. A staff nurse completed the man's reception health screening on Monday 14 July. Prison Service Order 3050 requires that prisoners are assessed by a member of healthcare staff during the reception process before they spend their very first night in prison after entering custody. The man had been in custody for some months and was being transferred in from another prison. In these circumstances, a health screening is only recommended before the first night. He arrived on a Friday. The nursing staff finished work at about

4.30pm that day, and no healthcare staff work on weekends. It was therefore reasonable that the man did not undergo a health screening until the next working day (Monday).

30. The man did not report any significant health concerns to the staff nurse. He was still being prescribed 125mg daily of amitriptyline on an ongoing basis to tackle depression. His blood pressure was found to be raised, as it had been at Lewes, and as a precaution this would be checked again a week later. The man also mentioned that he had certain allergies. He was prescribed diclofenac (a painkiller) for up to 14 days for a headache.

31. A few days later (18 July 2008), the man was examined by a staff nurse again after he complained of a headache. She took his blood pressure, and recorded a reading of 169/94. The man had already been prescribed diclofenac on 14 July and paracetamol on 15 July, but his headache persisted. The staff nurse consulted with a prison doctor regarding the man's symptoms and co-dydramol (a painkiller containing paracetamol and dihyrocodeine) was prescribed for up to 14 days.

32. The man told another nurse that he continued to suffer from headaches on 21 July. He expressed concern because of the strokes that had affected his father's health. His blood pressure was checked and was again found to be raised. The second nurse made an appointment for the man to be assessed by a doctor on the following day.

33. The next day (22 July), the man was examined by another prison doctor. The doctor found that he had essential hypertension, more commonly referred to as high blood pressure. The doctor ordered blood tests and decided that he should undergo an electrocardiogram (ECG), which would check on the activity of his heart and show whether anything unusual was happening. The doctor prescribed bendroflumethiazide (a drug designed to relieve hypertension) for up to 28 days, and ibuprofen (also for up to 28 days) as pain relief medication to treat the man's headaches. The prescription for bendroflumethiazide was renewed on 18 August (for 28 days), 22 September (for 7 days) and 29 September (for 28 days).

34. The man's blood was taken on 25 July. He also underwent an ECG at the same time. The results of the ECG were unremarkable. The results of the blood tests arrived on 30 July, and also indicated nothing out of the ordinary aside from a cholesterol problem. The man continued to be prescribed bendroflumethiazide to treat his high blood pressure, but his medical records seem to indicate that his blood pressure was not checked again until the day of his collapse. A review had been scheduled within the next two to six weeks, but did not take place.

35. A prisoner who had befriended the man told my investigator that approximately three or four weeks after the man arrived at Erlestoke he complained of headaches. The prisoner said that the headaches would sometimes cause the man to miss work, which he did not like to happen.

36. The man sent his family a letter on 3 August complaining that he had recently been experiencing headaches. The letter said:

> '… I had a headache for two weeks solid. It was unbearable.'

His parents were kind enough to provide my investigator with a copy of the letter, in which the man told them that he had initially been prescribed paracetamol to address the headache. A week later, the headache had not improved. The man said that he was then assessed by a 'senior nurse', who found that he had high blood pressure. The following day he was referred to a doctor, who also diagnosed high blood pressure.

37. The man wrote in his letter that the doctor had prescribed medication for his high blood pressure and pain relief for his headache, as well as listing him for blood tests. He wrote that the doctor had told him that the tests gave no cause for concern, aside from high cholesterol. However, the doctor acknowledged the history of high blood pressure in the man's family, and told him that his blood pressure would be checked regularly. The doctor told the man he would need to take medication to tackle his high blood pressure for the foreseeable future. In the letter, the man told his parents that his headache had stopped after two weeks.

38. From 19 August, the man was again prescribed co-dydramol by a doctor. He was to take two tablets four times a day. He continued to be prescribed eight tablets of this codeine-based medication per day until 21 October. The man obtained the pain relief tablets from the pharmacy in the healthcare centre. This prescription was rewritten and signed by a doctor on 3 and 19 September. He was prescribed ibuprofen on 28 August for up to 56 days.

39. Prison records indicate that, by August, the man had found employment in the Speedy Hire workshop, and was studying to complete a National Vocational Qualification (NVQ). On 8 September, he went before an IEP review board and became an enhanced prisoner. (Enhanced is the highest of the IEP levels.)

40. Records indicate that the man underwent an eye test with an optometrist for the prescription of new glasses on 10 September (he received the new glasses on 25 September). On 11 September, he was prescribed six ibuprofen tablets for another headache.

41. The man was examined by the staff nurse on 30 September. He complained of a generalised headache. The nurse asked about any nausea or visual disturbances, but he said that he was not experiencing either. The nurse advised the man to take the pain relief he had already been prescribed, and to ask to see the doctor if the pain continued. The staff nurse did not observe any deterioration in the man's condition on this occasion. In interview, she said that the man remained cheerful and approachable throughout his time at Erlestoke.

42. On 6 October, an officer issued the man with a formal warning because he was not going to work. She spoke with him the following day, having noticed a change in his mood. She felt that the man's failure to attend work was out of character. She told my investigator that he had usually been keen to work at the Speedy Hire workshop. She observed that the man seemed to be struggling to cope. She was reluctant to issue him with another warning and therefore spoke to him out of concern.

43. When this officer asked the man 'if everything was okay', he became visibly upset. She took him into the senior officer's office on Wren Unit and they had a conversation. The man told the officer that he was experiencing significant anxiety. He was concerned about his family, particularly his father's ill health, and he was also feeling emotionally drained by his dealings with a younger prisoner who regularly turned to him for advice. The man was finding it difficult to deal with his own problems in addition to the other prisoner's. A referral was made on 7 October for him to discuss his emotional difficulties with a mental health nurse.

44. This officer did not observe any apparent physical deterioration in the man. In interview, she said that he continued to keep his cell clean and to look after himself. She attributed the man's failure to go to work not to any particular decline in his physical health, but rather to the emotional pressures he had described to her. Another officer also felt that anxiety and stress had caused the man to 'go downhill emotionally'.

45. When she spoke with my investigator, the officer who had a conversation with the man could not recall him discussing any headaches or ongoing physical health problems with her. She said that she had seen him very regularly on Wren Unit between July and October. She felt that he might have attributed any headaches he was experiencing to emotional stress.

46. The man told the officer that he wanted to move onto Alfred Unit to be closer to his friends, and to avoid having to deal with the younger prisoner's problems any longer. He moved onto Alfred Unit on 16 October. The officer recalled that the man was very happy to have made this move. He was allocated cell 28 and was assigned a personal officer.

47. At some stage before his collapse on 23 October, the man wrote a letter to his parents which they received on 24 October. They told my investigator that the man had written that he was taking his medication to address his high blood pressure, and that, if he did not, he experienced a painful headache. He told his parents that he had not suffered headaches like these before.

48. A fellow prisoner and friend told my investigator that the man had experienced a more severe headache in the early hours of 23 October. The friend said that another prisoner in the neighbouring cell to the man had reported hearing him moaning in the night. The friend said that the other prisoner had felt that the man had been in considerable pain and the other prisoner told the friend that the man had rung his cell bell more than once. The other prisoner told the friend that the night staff had not acted as a result of the man's requests.

Instead, the other prisoner said that the man had had to wait until the morning to be examined by a nurse.

49. When a prisoner presses their cell bell, a light goes on and a buzzer sounds in the unit office where the staff are based overnight. The system identifies the relevant cell, and there is also a flashing light outside the cell to show which prisoner requires assistance. My investigator has confirmed that cell bell records are not kept at Erlestoke.

50. The prisoner who spoke to the man's friend left a telephone number with Erlestoke's family liaison officer. He was released from custody and my investigator was unable to reach him on the telephone number provided to discuss the events described by the friend. A third prisoner also asked to speak with my investigator. However, he was released from Erlestoke before an interview could be scheduled. My investigator wrote to the third prisoner at the release address he provided, but received no reply.

51. My investigator interviewed the Night Patrol Operational Support Grade (OSG) who was working alone on Alfred Unit from 8.30pm on 22 October until 7.30am on 23 October. (It is usual for there to be only one member of staff on each unit during the night.) As an OSG, he is locked in the unit and cannot open cell doors during the night unless there is a situation where immediate intervention is required. In those circumstances, a sealed pack of keys can be opened, but only once the night orderly officer (NOO) has arrived on the unit. The OSG working the night shift is not allowed to pass any non-prescribed pain relief medication through the cell door flap.

52. When the OSG began his shift, he was told during the handover that there were no problems with any of the prisoners. He then performed an initial check around the unit, which was uneventful. He was visited during the night at regular intervals by the night orderly officer, who is responsible for the prison during the overnight period and is first aid trained.

53. The OSG told my investigator that the man pressed his cell bell for the first time at about 7.05am, just before his shift finished. Prior to this, he said that two other prisoners had pressed their cell bells in order to have their lights switched off. He said that no other cell bells had been activated during the night. The OSG said he had had no other interaction with the man during the night before he pressed his cell bell, and had had no cause to be concerned for him. He said that he had performed approximately half hourly checks around the unit, looking randomly through different observation flaps to check on the safety of prisoners. He did not hear anything unusual, such as somebody being in pain.

54. The OSG went to the man's cell at 7.05am, cancelled his alarm and opened the observation flap on his cell door to speak to him. During interview, he recalled that the man had said that he was worried because he was 'not feeling too well', had a history of high blood pressure and was feeling faint. The man did not tell the OSG that he had a headache. He said that he was

feeling 'quite scared' and asked the OSG if he could be assessed by a doctor that morning.

55. The OSG remembered that the man had looked tired when they spoke, but he had not been unduly alarmed by what the man had said. He did not consider that this was a situation that required consulting the out of hours healthcare service. If he had reported more serious symptoms, the OSG told my investigator that he would have telephoned the NOO to consult with them. The NOO would have come to the unit, assessed the situation, and could have called out either a doctor or an ambulance. The OSG said that he felt confident to consult with the NOO if he had urgent concerns about a prisoner.

56. Returning to the unit office, the OSG made a note in the wing observation book. He telephoned the NOO and the control room to say that the man wanted to be examined by a member of healthcare staff as soon as possible. He left a note for the day staff who were coming onto the unit to the same effect. When the day staff arrived, the OSG told them about the man's request and finished his shift.

57. The OSG's telephone call to the NOO was noted on the daily occurrence sheet. The entry reads as follows (the time indicated is 6.56am, a few minutes earlier than the OSG recorded it):

> 'The OSG called from Alfred to say that [incorrect name] was feeling faint and suffers from high blood pressure. [The OSG] advised that the prisoner lie down until unlock at 7.30 and then approach an officer to see healthcare.'

58. An incorrect name appears to have been written down by the other member of staff in error. (Given that the other prisoner was in the cell next door and apparently spoke to the man overnight, his name may have been mentioned by the OSG and written down in error.) The OSG however used the man's name when he wrote in the wing observation book as follows:

> 'At approx 7.05am, the man rang his bell stating he suffers from high blood pressure. He is feeling faint and is quite scared. Comms, NOO informed. Note left for wing staff to make appointment with healthcare asap.'

59. An officer told my investigator that he began a day shift on Alfred Unit at 8.00am on 23 October. He said that the man's request to be assessed by one of the healthcare team was not passed to him directly, but was written in the wing observation book which all staff read when they start their shift. He confirmed that the prisoners were unlocked between 8.00am and 8.30am in order to get their breakfast and make 'special sick' applications in order to be examined by a nurse that morning if they felt unwell.

60. Between 8.00am and 8.30am, this officer remembered that the man came to the wing office and reiterated that he wanted to make a 'special sick' application. This had already been arranged as a result of the OSG's actions.

The officer did not recall the man looking especially unwell when he came in to make the request. He said that the man looked about the same as usual, and mentioned that he had a headache.

61. The officer said that the man then returned to his cell. He believed that the man had laid down on his bed and waited for his appointment with the nurse. The man would have been checked again by staff at about 8.50am, during roll call and lock up. The officer confirmed that the man's cell was unlocked at about 9.20am so that he could be assessed by the nurse. He recalled that the man made his own way to the examination.

62. The man was assessed by a staff nurse in the large association room on Alfred Unit at about 9.25am. He appeared pale at this point and was not smiling, as the nurse remembered he usually did. The man told her that he was frightened, and he complained of a pain on the right side of his head. The nurse checked that the man was taking his prescribed medication correctly, and that he was not taking any illicit drugs or medication which had not been prescribed to him.

63. The staff nurse sat the man down and prepared to take his blood pressure using a standard piece of equipment called a sphygmomanometer. As she reached into her bag to retrieve a thermometer to check the man's temperature, she heard him say, 'Pain'. She turned back round and found that the man had collapsed. His head had slumped to the right and he had started to turn blue. The nurse lifted the man's head so that his airway was not obstructed and called for urgent assistance. In interview, the officer remembered the nurse calling out, 'Help!' The man's collapse took place within about a minute of his arrival in the association room.

64. The staff nurse told my investigator that there were about five members of staff on the wing when she called for assistance. An officer arrived in the association room and assisted the nurse to lower the man to the floor. The man remained unresponsive as the officer took his legs and the staff nurse took his shoulders to lower him into the recovery position on his left hand side.

65. Another officer recalled that, arriving in the association room, he had initially thought that the man might have been attacking the nurse as he seemed to be on top of her. He realised immediately that she was actually trying to support the man and prevent him from toppling to the floor after he collapsed.

66. The staff nurse began maintaining the man's airway and asked for an ambulance to be called. She also instructed that a doctor and nurse should come from the healthcare centre and bring the emergency response bag with them. A blanket was placed under the man's head, and the staff nurse also supported it with her hand. She kept the man warm and maintained him in the recovery position, ensuring that his airway remained clear.

67. The staff nurse's instructions were radioed across to the prison's control room. The Deputy Governor, who was duty governor on 23 October, spoke with the control room and made his way over to Alfred Unit.

68. Because the man was still breathing, was not having a fit and was not externally injured, there was nothing else healthcare staff could practically do to treat his condition. A prison doctor and nurse made their way to Alfred Unit to assist the staff nurse. They brought the emergency response bag from the healthcare centre, allowing oxygen to be administered.

69. An ambulance was called at 9.33am. It entered the prison at 9.46am (a second ambulance arrived five minutes later). Once the paramedics had arrived on Alfred Unit, the doctor assisted them by inserting a Venflon (a needle to allow the delivery of fluids intravenously into the body). The man remained in a stable condition as he was transferred from the unit to the waiting ambulance. Staff believed the man to have been aware of his surroundings to some degree, and the staff nurse tried to comfort and reassure him. Prison officers helped to lift him onto a trolley.

70. An escort chain was attached to the man before he left Erlestoke. This consists of a length of chain with a cuff at either end. One cuff attaches to the prisoner, the other to the escorting officer. The ambulance departed Erlestoke at 10.05am, arriving at hospital at 10.55am. During the journey, the man complained of severe head pain. Upon arrival, it is believed that he suffered a fatal bleed in his brain. He was having a fit and was taken directly to the resuscitation room. He was subsequently placed in a medically induced coma.

71. The escorting officers removed the escort chain from the man at 11.00am after they updated the Deputy Governor of the situation by telephone and obtained his permission. The man was not cuffed again at any point. At 11.05am, prison healthcare staff were asked to fax across his medical records.

72. At 11.30am, the escorting officers contacted the control room at the prison and informed staff that the man was seriously ill, and that his next of kin should be told as a matter of urgency. The Deputy Governor spoke with the man's offender supervisor, who told him that the man's parents were the designated next of kin.

73. Being aware that the man's father was not in very good health himself, the Deputy Governor thought that the news should be broken to them carefully. He therefore asked Wiltshire Police's Prison Intelligence Officer to contact the Metropolitan Police. The Intelligence Officer did this just after 1.30pm on 23 October, asking that a local police officer visit the man's parents to tell them that their son had been admitted to hospital.

74. Shortly before 1.00pm, the escort officers were told that the man had suffered a significant brain haemorrhage, and that he would be transferred to the Intensive Care Unit (ICU) at the hospital to allow an operation to take place. Although two officers had initially been assigned to bedwatch duty, this number was reduced to one at 3.00pm. A single officer escort remained with the man for the next week, but stayed in a room nearby.

75. A police officer visited the man's parents' home at about 5.20pm. The Governor spoke with the man's father on the telephone at approximately 5.40pm, and assured him that the prison would assist with transport and accommodation costs to allow them to visit their son.

76. The man was transferred from this hospital in an ambulance at about 5.00pm, whilst the escorting prison officer travelled separately. The ambulance arrived in Southampton shortly after 6.00pm. The man underwent an operation to relieve the pressure on his brain which had resulted from the bleed at 7.45pm. He was kept in a medically induced coma.

77. The Governor and Family Liaison Officer visited the man in hospital at 8.30am on 24 October. They spoke with ICU staff about the operation which he was to undergo. Hospital staff spoke with the man's mother on the telephone to obtain her consent for the operation. After they had done so, the Governor also spoke with her at 9.15am. She told the Governor that she and her husband would not be able to travel to the hospital that day. The Governor reminded her that the prison would help to pay for their travel and accommodation when they were able to visit their son in hospital. The man was operated on and returned from surgery at 1.40pm. He remained in a medically induced coma.

78. The Governor and Deputy Governor maintained regular daily telephone contact with the man's parents and sister throughout this period. The Governor also visited the man in hospital again at 12.45pm on 25 October.

79. Because the man's parents lived in Essex, and his father was not in the best of health, the Governor contacted the duty governor at HMP Chelmsford, the nearest prison to the man's parents. The duty governor organised a taxi to transport the man's parents from their home to Southampton at 8.30am on 26 October. The cost of this journey was paid for by the Prison Service.

80. Because the Governor had a prior engagement, the Deputy Governor went to meet the man's parents at the hospital at midday on 26 October. The intention had been for the hospital to organise accommodation in the locality for them, but they had not done so. In the event, the Deputy Governor used his own credit card to book two nights' accommodation for the man's parents in a nearby hotel. (He later reclaimed these expenses.)

81. The Governor visited the hospital at 2.30pm on 27 October to meet the man's parents. They stayed in Southampton until midday on 29 October, when they returned home. Staff at Erlestoke subsequently maintained regular telephone contact with them. Any decision as to whether their son would be released on temporary licence was delayed until his prognosis was clearer.

82. There was no change in the man's condition in the next few days. A single escorting officer remained at the hospital. Throughout the period he remained in hospital, the Governor issued a series of notices to both staff and prisoners

to keep them informed of the man's condition. He also reminded his staff of their entitlement to speak with the care team if they felt the need.

83. On 31 October, the man was released on temporary licence (ROTL). The bedwatch was ended at about 2.30pm, it being judged unnecessary and intrusive to keep an officer at the hospital any longer. Prior to the ROTL being granted, the Deputy Governor had spoken with the man's mother on the telephone to ensure that she understood why the decision was made.

84. Sadly, the man died just before 6.00pm in November 2008. The cause of death was a reduction of the flow of blood to his brain, caused by the blood vessels in the brain constricting. This happened after an aneurysm ruptured and bled. Essentially, the rupturing of the aneurysm caused him to suffer an initial, sudden brain haemorrhage. The subsequent loss of blood supply to his brain is something that can often then occur in these circumstances a week or so later.

85. The Family Liaison Officer (FLO) subsequently visited the man's parents at their home. A memorial service was held in the prison chapel at Erlestoke on 4 November, and was very well attended by about 40 prisoners. Fellow prisoners paid for a wreath at the funeral, and some sent letters, notes, poems and cards to the family. They were compiled into a folder by the FLO, who gave it to the man's parents when she returned his property to them.

86. The man's estranged wife contacted the prison on the day after he died. The Deputy Governor spoke with her and confirmed the man's death. He told the man's estranged wife that his parents had been named as the next of kin. The man's wife made two further telephone calls to the prison in the following weeks. She spoke with the Governor on both occasions.

87. With the family's consent, the Governor and the FLO attended the man's funeral on 19 November to represent the staff at Erlestoke. The prison met the cost of the funeral. The Governor subsequently expressed his condolences to the family in a letter, and continued to maintain telephone contact with them in the following weeks.

ISSUES

Clinical care

88. As noted earlier, a clinical review of the treatment the man received in custody has been completed. The clinical reviewer considered whether the healthcare he received was equivalent to that in the community. He has concluded that, with hindsight, the man was not treated 'as proactively as might have been ideal'. However, he also comments that a similar chain of events might well have taken place if the man had been under the care of a community doctor when he fell ill. The clinical review has enabled my investigator to answer the questions which the family raised.

89. The man entered Erlestoke in July. He first reported suffering from headaches later that month. He was assessed by a doctor, his high blood pressure was correctly identified, and appropriate medication (bendroflumethiazide) was prescribed. Blood tests were also carried out. The results of these tests gave no cause for concern, aside from a cholesterol problem. Pain relief medication was also prescribed to address the headaches the man reported.

90. At the start of August, the man wrote to his parents to tell them about the two weeks of headaches he had recently experienced. He told them that the headaches had now stopped. He did not report a headache again to healthcare staff until 30 September. The man was asked about his symptoms by the staff nurse on this occasion and prescribed pain relief. He did not present again to healthcare staff until the morning of his collapse.

91. In early October, the man's mood was noticed to have deteriorated by staff on Wren Unit. Two officers attributed his low mood to emotional stress, as he was worried about his family and was upset about his situation. The man did not tell the officers about headaches or other physical health problems.

92. The man did not report any other symptoms to staff until the morning of 23 October when he told the OSG that he had a headache, felt faint and would like to be assessed by the healthcare team. Just over two hours later, he collapsed as he was being examined by the Staff Nurse.

93. It would seem that the man's headaches were episodic. When he did report a prolonged period of pain, he was correctly referred to a doctor and blood tests were ordered. They did not highlight any obvious concerns, as they are not able to detect conditions such as an aneurysm.

94. The clinical reviewer confirms that individuals who suffer a brain haemorrhage as a result of an aneurysm can often report headaches prior to the fatal bleed. With the benefit of hindsight, the clinical reviewer considers that the isolated headache the man reported to the Staff Nurse on 30 September might have been an indication of the aneurysm which was about to rupture.

95. However, the clinical reviewer does not consider that the longer term history of headaches which the man may have experienced was necessarily associated with the aneurysm that eventually caused his death. From the medical records he has reviewed, he finds nothing to suggest that staff should have ordered either further tests or a CT scan. In other words, had the man presented with the same symptoms in the community, he would probably not have been sent for a scan either - unless he had presented with additional symptoms.

96. As the clinical reviewer comments, headaches are very common. He also suggests that, as prison is a particularly stressful environment, it can make the presentation of headaches even more likely.

97. Nonetheless, the clinical reviewer expresses concern that more in depth questions were not put to the man about his headaches when he was examined by a doctor in July. It does not seem that the man was asked about the precise nature of his headaches until he complained of head pain again at the end of September and was examined by the Staff Nurse.

    The Head of Healthcare should ensure that patients reporting persistent headaches are asked appropriate questions during examination.

Medication

98. The man was prescribed 125mg daily of amitriptyline on a long term basis during his time in prison. The clinical reviewer told my investigator that a high dosage of this drug acts as an anti-depressant, whilst a lower dosage can reduce anxiety and act as a sleeping tablet. It cannot become addictive in the way that diazepam (Valium) can. The clinical reviewer comments that this medication is probably quite widely used in the prison population. He says that amitriptyline can also reduce chronic pain, and so was an appropriate drug in this instance, even for long-term use.

99. From 19 August, the man was prescribed eight tablets daily of co-dydramol (a pain relief medication containing paracetamol and dihydrocodeine). He had previously been prescribed this drug for a short period in July. His prescription was renewed on 3 and 19 September. He collected his medication from the pharmacy in the healthcare centre until 21 October. The man was allowed to be 'in possession' of the medication, meaning that he was trusted sufficiently to be given a supply of it in advance to keep in his cell for his own use. Sometimes the man would collect it daily, and on other occasions he would pick up several days worth in advance.

100. A fellow prisoner said that the man had complained of headaches at intervals during his time at Erlestoke. However, the man does not seem to have communicated this to staff on his unit. In interview, two officers both recalled that they had found the man to be a polite and easy going prisoner who did not complain of physical health problems. A Staff Nurse also said that she had found the man to be cheerful and welcoming when she had examined him. The officers noticed a change in his mood in early October. Similarly,

when the Staff Nurse assessed the man on 23 October, she noticed that (for the first time in her experience) he looked upset and agitated.

101. Both officers felt that the man's low mood in early October was due to emotional stress, rather than any physical pain. He was referred to a mental health nurse as a result. It would appear that the man's headaches may have been episodic, and that he either did not feel the need to complain, or tended to complain to friends in the prison rather than to healthcare or discipline staff.

102. It is debatable whether doctors accurately monitored the man's use of co-dydramol. They did sign off repeat prescriptions in September on an 'as required' and 'in possession' basis. There does not seem to have been any significant further attempt to secure an accurate diagnosis of the man's condition. The clinical reviewer believes that this type of medication can have the unintended consequence of actually prolonging headaches if taken continuously. It should not have been prescribed repeatedly without the man's symptoms being further explored. Its long-term use is not recommended.

The Head of Healthcare should ensure that long term medication is not prescribed to prisoners unless a firm diagnosis has been made and a treatment plan has been devised. A doctor should regularly review any such prescription.

103. Co-dydramol contains dihydrocodeine, an opiate substitute much milder than heroin. The clinical reviewer speculates that the presence of this chemical may have been part of the reason that the man continued to take this medication. Rather than using it to address his headaches, he may have been taking it because it acted as a very mild substitute for heroin.

104. The man had misused drugs in the community, and had also done so recently in prison. He had lost his employment at Lewes as a result of his drug misuse. He had been observed to be heavily under the influence of drugs at the end of June, shortly before he was transferred to Erlestoke. He was also the subject of several Security Information Reports regarding other prisoners' prescribed medication.

Treatment of the man's high blood pressure (hypertension)

105. As the clinical reviewer highlights, healthcare staff at Erlestoke correctly identified that the man was suffering from high blood pressure in July 2008. This was the only other symptom identified apart from headaches before the man collapsed. The doctor prescribed bendroflumethiazide to address the hypertension and it was decided that the man's blood pressure should be subsequently reviewed. However, the reviews do not seem to have been carried out. The man continued to be prescribed bendroflumethiazide until he collapsed in October.

106. The man was examined by an optometrist when he needed new glasses in September. The clinical reviewer points out that part of this procedure would

usually involve an examination of the back of the eye. Evidence of chronic raised blood pressure would usually be visible during this procedure. It does not seem that the optometrist reported any concerns in this regard.

107. The intention of the reviews was to assess whether the prescribed medication, which is a common drug used to treat high blood pressure, was having the desired effect. Although the reviews were not performed, the clinical reviewer believes that the man collected and took his medication.

108. I note that the man's high blood pressure was identified when he arrived at Lewes in December 2007. However, as the clinical reviewer remarks, no reviews of his condition were scheduled on that occasion either. The man had just come into custody, and there may have been an assumption that his crack cocaine misuse had led to the raised blood pressure.

The Heads of Healthcare at both Lewes and Erlestoke should ensure that, when a prisoner is diagnosed with high blood pressure, scheduled reviews are carried out as planned. Whenever blood pressure is taken, the reading should be recorded in the prisoner's notes, whether abnormal or not.

109. The clinical reviewer says there is not necessarily any direct relationship between high blood pressure and the haemorrhage that caused the man's death. Whilst high blood pressure can increase the likelihood of an aneurysm bleeding, brain haemorrhages can occur in people with normal blood pressure. The clinical reviewer also stresses that, whilst the man's blood pressure was found to be very high after he collapsed, this is not necessarily an indication that it had been as high in the days beforehand. Blood pressure can rise in reaction to a brain haemorrhage.

The night before the man's collapse

110. As I have already outlined, my investigator has spoken with a prisoner who was held on Alfred Unit at the time of the man's collapse. He claimed that the man had been in considerable pain overnight prior to his collapse in front of the Staff Nurse on the morning of 23 October. He said that another prisoner was in the neighbouring cell and had heard the man ringing his cell bell and making noises indicating that he was in pain. The man's friend said that the prisoner in the neighbouring cell had been concerned that no help was brought to the man overnight and that he had had to wait until the nurse arrived in the morning.

111. The prisoner in the neighbouring cell was released from custody before he could be interviewed. My investigator has called him since on the telephone number he provided to the FLO. Unfortunately, the investigator was unable to get in touch with him. Another prisoner came forward to speak with my investigator but was also released from Erlestoke before an interview could be arranged. My investigator wrote to him at his release address, but did not receive a reply.

112. My investigator has interviewed the OSG who worked on Alfred Unit overnight prior to the man's collapse on the morning of 23 October. The OSG said that the man activated his cell bell at 7.05am and that he had had no reason to be concerned about the man beforehand. The OSG reported that the man had not pressed his cell bell during the night. At 7.05am, the man had asked to see a member of healthcare staff and told the OSG that he felt faint and was 'not feeling too well'. The OSG did not consider this to be an emergency. He advised the gate staff, made a note in the wing observation book, and passed the request on verbally to the day staff as he was going off duty. As a result, the Staff Nurse assessed the man just over two hours later.

113. The OSG said that he felt confident to call upon the advice of the night orderly officer if he was concerned about a prisoner's health, or was unsure whether to call either a doctor or an ambulance. He made a note of what had happened in the unit's observation book, which my investigator has checked. Unfortunately, there is no facility at Erlestoke to record the activation of cell bells, so there is no means of confirming when the man did activate his bell.

114. In the absence of any other evidence, I presume that the events described by the OSG are essentially accurate. The information provided by the prisoners cannot be confirmed, and I consider that the OSG was well aware of the options if a prisoner fell ill overnight. He did log the man's request for a medical examination, and the man was assessed by the Staff Nurse promptly during morning rounds.

Whether the man's collapse was related to previous head injuries

115. The man's family have expressed concern that his collapse might have been related to a skull fracture he sustained during an assault at HMP Lewes. Consulting prison records, my investigator has found that the man does appear to have been the victim of an assault at Lewes in 2004. A Security Information Report confirms that he had been assaulted on 26 July 2004, and had sustained 'serious facial injuries'. However, the man would not tell staff who had assaulted him and insisted that he had been injured falling down stairs. Staff seemed aware at the time of who had carried out the assault. However, without the man's assistance, they were unable to take the matter any further.

116. My investigator has not found any evidence of the man sustaining other head injuries in custody. He was also held in Lewes from December 2007 until July 2008, prior to his transfer to Erlestoke, but it would seem that the incident to which the family referred took place four years prior to his death.

117. Given the length of time that elapsed between the assault and the man's death, it is difficult to show any association between the two events. Similarly, a motorcycle accident during which the man was injured apparently took place almost two decades ago in 1991. The clinical reviewer comments that he would not expect any injury sustained in either a fight or a road accident to have contributed towards the eventual cause of the man's death.

118. Similarly, the clinical reviewer does not find any direct connection between a history of strokes in the man's family and the rupture of the aneurysm in his brain which caused his death. Strokes tend to be caused by a hardening of the arteries, whereas an enlarging aneurysm is a different type of health problem, albeit with similar outcomes in the eyes of a layperson.

Whether an unsupervised detoxification process in prison may have triggered the bleed in the man's brain

119. The clinical reviewer believes that there is no evidence that the man underwent either an inappropriate or too rapid detoxification procedure whilst in either Lewes or Erlestoke. He had relapsed into drug misuse in the community before he returned to prison in December 2007. No ill health was reported as a result of the man's participation in an organised detoxification procedure at Lewes. He subsequently continued to misuse drugs in custody, and lost his employment and enhanced prisoner status in June 2008.

120. Whether the man was actively misusing drugs such as benzodiazepines, or whether he withdrew from these drugs of his own accord without proper supervision, the clinical reviewer confirms that neither event was likely to have contributed to the rupturing of the aneurysm that caused his death. The clinical reviewer commends the detoxification procedure at Lewes.

Medical records

121. The clinical reviewer is critical of the occasionally poor record keeping amongst healthcare staff at both Lewes and Erlestoke. I endorse his comments that the name of the prison, the name of the prisoner, and the identity of the member of staff making the entry, should all be legible on every part of a prisoner's medical record.

Response to the man's collapse

122. I consider that the Governor, the Deputy Governor and Family Liaison Officer largely dealt extremely effectively and sensitively with the man's collapse and subsequent death, particularly with regard to the care afforded his parents. The initial response on Alfred Unit was also rapid and carried out appropriately by both medical and discipline staff.

123. A sensible and quick decision was made by the Deputy Governor to remove the escort chain from the man after he arrived at hospital on the morning of 23 October. The restraints were not used again, which was particularly helpful when his family visited him. The reduction of the bedwatch staff to a single officer was also a measured and appropriate decision.

124. The Deputy Governor organised for a member of the Metropolitan Police to personally attend the man's parents' home on the day of his collapse to tell them what had happened. This was sensitively handled, as the man's father had himself been in poor health. The distance between Erlestoke and the family's home was considerable, and the use of the local police was

appropriate. Another option might have been for a trained family liaison officer to have attended from a nearby prison, as recommended (albeit in the event of a prisoner's death) in Prison Service Order 2710. The management team may wish to bear this in mind in the event of a similar situation arising in the future.

125. In the first few days following the man's collapse, either the Governor or the Deputy Governor visited him in hospital on a daily basis. Taking account of his father's ill health, the management team organised for a taxi to transport the man's parents from their home in Essex to the hospital in Southampton. When accommodation was required for the man's parents, the Deputy Governor paid for this with his own credit card before reclaiming the expenses. Both the Governor and Deputy Governor spent time with the man's parents at the hospital and spoke to them on the telephone.

126. After the man's death, the FLO visited his family. A memorial service was held in the prison, and an album of letters and poems from prisoners was compiled and given to the man's parents. I understand that both gestures were appreciated by the family. The prison also paid for the funeral and the management team personally returned the man's belongings to his parents. The Governor and the FLO attended the man's funeral, and the Governor wrote a personal letter to his parents. I understand that he has maintained telephone contact with them since.

I commend the compassion and support shown to the man's parents by the Governor, the Deputy Governor and Principal Officer after his collapse and following his death.

127. The care afforded the man's parents was exemplary. However, his estranged wife told my family liaison officer that she felt she had not been listened to by staff at Erlestoke. She considered that the man's parents, who were the named next of kin, were prioritised, whilst her needs were not sufficiently acknowledged. The guidance for Family Liaison Officers attached to Prison Service Order 2710 (concerning the follow up to deaths in custody) states:

> 'The family may be large, split geographically, at odds amongst themselves. Many modern families are split by divorce or separation and there may be several branches all with equal rights to information. The Family Liaison Officer may be able to get the family to nominate a single point of contact who undertakes to keep other family members up to date. This may not always be possible, or may not work in practice, so the Family Liaison Officer should be prepared to deal with different sections of one family if necessary.'

128. The man and his wife had become estranged but they were not divorced. She had visited him in custody, and had sent him a postal order just before he died. The man had named his parents as his next of kin, but this was a relatively recent development. The guidance does indicate that other members of the family besides the named next of kin may have needs to be met after a prisoner dies.

129. The man's wife has told my family liaison officer that she has been greatly affected by his death. She was upset that she had found out about his collapse from an acquaintance, rather than being contacted by somebody from the prison. She wanted the postal order to be returned to her.

130. I understand that the postal order had been given to the man's parents amongst his belongings, and that the management team at Erlestoke have not reimbursed the man's wife, despite her request. While I am sympathetic to her, I do not think the taxpayer is actually liable for the money. While I make no formal recommendation, it may be possible for Erlestoke's family liaison officer to ask the man's parents to return the postal order which was given to them. Alternatively, the Governor should consider making an ex gratia payment to the man's estranged wife.

131. The Deputy Governor said that he spoke with the man's estranged wife when she telephoned the prison on the day after he died. She asked for confirmation of the man's death. She was upset that nobody had called her, and it was explained to her that she was not the named next of kin. The Governor subsequently spoke to the man's wife on two further occasions.

132. I understand the difficulties of managing the expectations of different members of a family, but it is not surprising that staff should feel obliged to deal primarily with the named next of kin. No doubt they were conscious of the need to look after and prioritise the man's parents, whose health was not especially good.

133. Nonetheless, the man's estranged wife's perception is that she was not acknowledged at a time when her estranged husband had died. In future, if a death occurs at Erlestoke, the management team may want to consider how they can ensure that such a perception does not arise again, and that any relatives who present themselves are given due consideration.

The lack of an appropriate treatment room and an emergency response bag on each unit

134. When the Staff Nurse assessed the man on 23 October, she did so in a large association room on Alfred Unit. This room is unsuitable for medical examination. There is no appropriate room allocated for this purpose on either Alfred Unit or any of the other units. The association room is extremely large and has few chairs. It is not warm and lacks privacy. A nurse performing assessments must do so whilst using equipment from their bag. When the man collapsed, he did so in a public space.

135. Just as each unit lacks an appropriate treatment room, there is a similar absence of emergency response bags. When the man collapsed, the bag had to be brought over from the healthcare centre. In this case, it did not affect the care he received as he was breathing and uninjured. However, the presence of an emergency response bag on a residential unit, where it can be accessed within seconds, could prove critical to a successful outcome.

136. Whilst the healthcare centre itself has recently been significantly upgraded, the lack of treatment rooms would appear to be largely a funding issue. My investigator has discussed this matter with the Governor. He accepted that Erlestoke lacks suitable treatment rooms for healthcare staff to use when they carry out assessments on the residential units.

137. The Deputy Governor addressed the concerns I had raised in a letter dated 18 February 2009. He wrote that the management team had been unable to assign a room on each of the residential units for healthcare assessments. He indicated that he and the Governor would therefore consider whether prisoners requesting ‘special sick’ applications at breakfast could be assessed in the healthcare centre, rather than on the residential units. He confirmed that an emergency response bag and defibrillator were soon to be located in three areas of the prison, with the intention of providing easier access in the event of an emergency. I welcome these developments.

Conclusion

138. The man’s death was unexpected, and I recognise how upsetting the circumstances must have been for his family. However, I have been pleased to note the exemplary treatment the man’s parents received from the Governor and his staff after he collapsed. My investigation has highlighted several areas of concern for the Governor and Head of Healthcare to address. However, guided by the findings from the clinical review, I do not believe that there were any significant failures in the care the man received in custody.

RECOMMENDATIONS FOR ERLESTOKE

1. The Head of Healthcare should ensure that patients reporting persistent headaches are asked appropriate questions during examination.

   The prison accepted the recommendation. A series of triage protocols are under development at Erlestoke. A protocol relating to headache presentation has been agreed and is now in use. This measure is intended to ensure that each prisoner is treated in the same manner, regardless of the individual knowledge, experience and background of healthcare staff.

2. The Head of Healthcare should ensure that long term medication is not prescribed to prisoners unless a firm diagnosis has been made and a treatment plan has been devised. A doctor should regularly review any such prescription.

   The prison accepted the recommendation and has briefed its doctors on the proposed changes. The Head of Healthcare has agreed that all prisoners in receipt of long term medication will have their prescription reviewed every six months. If the prisoner has a chronic disease then a chronic disease management plan will be put in place.

RECOMMENDATION FOR ERLESTOKE AND LEWES

3. The Heads of Healthcare at both Lewes and Erlestoke should ensure that, when a prisoner is diagnosed with high blood pressure, scheduled reviews of this condition are carried out as planned. Whenever blood pressure is taken, the reading should be recorded in the prisoner's notes, whether abnormal or not.

   Erlestoke accepted the recommendation. The Governor confirmed that the prison has set up a blood pressure clinic where all prisoners with high blood pressure will be reviewed at least every six months, and possibly more frequently depending on their most recent blood pressure reading.

GOOD PRACTICE AT ERLESTOKE

1. I commend the compassion and support shown to the man's parents by the Governor, the Deputy Governor and Principal Officer after his collapse and following his death.

THE RESPONSE OF THE FAMILY TO THE DRAFT REPORT

The man's sister wrote to my Family Liaison Officer (FLO) on behalf of her family on 21 July. She raised quite a number of questions. My investigator replied on 3 August, providing her with responses to her queries. The man's sister wrote to my FLO on 4 September, indicating that, '…after much thought, [my family] feel that we are not going to get any further…' As a result of the man's sister's questions, my investigator has made several alterations to the original draft report. These have been added at paragraphs 24, 27, 34, 60 and 61.