Investigation into the circumstances surrounding the death of a man at HMP Hewell in February 2011

Report by the Prisons and Probation Ombudsman for England and Wales

October 2011

This is the report into the death of a man in February 2011, whilst in the custody of HMP Hewell. He was 64 years old. A post mortem concluded that he died from chronic obstructive airways disease with evidence of cor pulmonale (right sided heart failure). I offer my condolences to his friends and family for their loss.

One of the family liaison officers (FLO) contacted the man's family and friends to inform them about the investigation and to provide an opportunity to raise any issues about the care he received in custody.

The investigation was carried out by my colleague. She and I would like to thank the Governor of HMP Hewell and his staff for their co-operation during the course of our enquiries.

I also thank the local Primary Care Trust for appointing a clinical reviewer to review the man's clinical care. As he died from natural causes the findings of the clinical review were essential to my own conclusions. The review concludes that the standard of care he received was equitable to that which he could have expected in the community.

The inquest was heard, with a jury, on 22 June 2011, and concluded his death was due to natural causes.

I make four recommendations, which address the location of emergency resuscitation equipment, completion and recording of health screening assessments, induction for nursing staff and staff support.

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

Nigel Newcomen
Prisons and Probation Ombudsman **October 2011**

CONTENTS

Summary

The investigation process

HMP Hewell

Key events

Issues

Conclusion

Recommendations

SUMMARY

1. The man was arrested on 9 February 2011 and appeared at Magistrates' Court on 11 February. He was remanded into custody and sent to HMP Hewell. On arrival, he had a first reception health screen with a nurse where he did not disclose any medical conditions, other than suffering from an upset stomach due to stress. He was seen by a prison doctor the following day where he expressed no concerns about his physical or mental health and was told to seek advice if needed. He had no further contact with healthcare staff during his time at Hewell until the night he died.

2. He complied with the prison regime over the next few weeks and did not raise any issues or concerns with staff. He was seen to be disorientated at times when finding his way around the houseblock, but was assisted by staff who said that the environment can be confusing for those without prior prison experience. He was in a single cell and, according to those staff members and prisoners my investigator spoke to during her visits to Hewell, he appeared to have maintained a low profile, choosing not to socialise with other prisoners.

3. He called for assistance using his cell bell at 12.55am on 25 February, when he became unwell. Prison and healthcare staff attended and initially his condition did not appear to be life threatening. However, his condition rapidly declined and paramedics attended. Despite efforts to resuscitate him, he was pronounced dead at 2.10am.

4. A prison family liaison officer visited the man's friend later the same day to break the news of his death, although she had already been advised of the news by the police. The prison offered financial assistance towards the cost of the funeral.

5. I am satisfied that the care he received at Hewell was comparable to that which could be expected in the community. I make four recommendations which address the location of emergency resuscitation equipment, the completion and recording of health screening assessments, induction for nursing staff and staff support.

THE INVESTIGATION PROCESS

6. The investigation was opened on 1 March 2011, when the investigator issued notices announcing the investigation to staff and prisoners. Another investigator visited the establishment on behalf of the first investigator. She met the liaison officer and collected the prison documents relating to the man. No prisoners or staff came forward in response to the notices of my investigation.

7. The investigator visited Hewell on 26 April. During this visit she interviewed four members of staff. She visited the houseblock and cell where the man lived and spoke informally with prisoners and staff members on duty. She had a discussion with the Chair of the Independent Monitoring Board (IMB), and met with the Governor. She returned to Hewell on 16 May, along with the clinical reviewer and interviewed three additional staff members. My investigator also revisited houseblock 6 and met with the Head of Healthcare. My investigator also spoke with West Mercia Police, where the man was held prior to being remanded into custody and who visited the establishment following his death.

8. Initial feedback from the investigation was provided, in writing, to the Governor on 18 May 2011.

9. The local Primary Care Trust (PCT) asked the clinical reviewer to review the man's clinical care on their behalf and he was provided with all relevant documentation to assist this review. I would like to thank him for undertaking this review and for his timely report.

10. The investigator contacted Her Majesty's Coroner for the Worcestershire area to inform him of the nature and scope of the investigation and request a copy of the post mortem report. Upon completion, the investigation report will be sent to the Coroner to assist his enquiries into the death. An inquest was heard, with a jury, on 22 June 2011, and concluded his death was due to natural causes.

11. The man did not inform the prison of any next of kin details. However, my family liaison officer (FLO) contacted his partner and friend on 29 March to inform them about the investigation and to invite them to ask questions or raise concerns about his care. The friend told my investigator that the prison's family liaison officer had been very supportive. She had a number of questions:

    - She was worried that, when she visited the prison after his death, she was shown a different cell to the one he lived in.
    - She wanted details on what medication he had been prescribed.
    - She wanted to know if he had bought illegal drugs or had been bullied while in prison.
    - She was concerned that, when she viewed he body, he had a bruise on his head.

I hope my investigation answers these questions and provides a better understanding of his time in prison. His friend received a copy of the draft report as part of the consultation period. Having considered the investigation findings, his friend indicated to my family liaison officer that she was unhappy some with aspects of the report. Some the issues raised have been addressed outside of this report, however his friend remains concerned about the amount of time it took for him to receive medical attention.

HMP HEWELL

12. HMP Hewell was created on 24 June 2008, by merging three separate prisons which were located on adjacent sites (HMP Blakenhurst, HMP Brockhill and HMP Hewell Grange). Hewell primarily serves the West Midlands, Worcestershire, and Warwickshire areas.

13. There were seven houseblocks, six of which are divided into wings and one which is dormitory accommodation. Houseblocks one to six accommodate prisoners remanded by the courts, those awaiting sentence and convicted prisoners who are awaiting transfer to other prisons. Wherever possible, prisoners are allocated to a houseblock according to their categorisation.

14. Healthcare is provided by the local Primary Care Trust. The unit has 24 hour nursing staff, with in-patient care situated on the lower floor of the unit.

Independent Monitoring Board (IMB)

15. Each prison has an IMB, whose members are appointed by the Secretary of State for Justice from members of the community. Their role is to satisfy themselves that the prisoners are treated humanely and justly and that there are adequate programmes for preparing prisoners for release. The IMB report directly to the Secretary of State if they have any concerns. They also submit annual reports on how the prison has met the standards and requirements placed on it. Members of the IMB have access to every prisoner, every part of the prison and every prison record.

16. The most recent annual report published by the IMB at Hewell covers the period from 1 December 2009 to 30 November 2010. In the overall judgement of the establishment, the Chair reports:

> "At the end of the last reporting year, the Board expressed concerns that further reductions in the prison's budget could have an adverse effect on any future consolidation or improvements. Reductions in budgets have continued. The prison has repeatedly met these demands with diligence. There is little indication that budget reductions are having a direct effect on offenders."

17. The IMB made no explicit comment on the healthcare screening of those newly remanded to the establishment or the induction process. The man did not submit a complaint to the IMB and they have no record of any contact with him during his time at Hewell.

HM Inspectorate of Prisons' report

18. The first inspection of Hewell by the HM Chief Inspector of Prisons was in November 2009. In her introduction to the report of the inspection, the then Chief Inspector said:

> “Managers had placed a commendable focus on safety, and most prisoners in the closed part of the prison reported feeling safe … The central reception was enormously busy, but professional and efficient. First night arrangements required development, specifically the new arrangements for Houseblocks 1-6.”

19. With regard to the support of prisoners who are new receptions to the prison the Chief Inspector said:

> “The recently revised first night arrangements, in particular the introduction of a dedicated first night landing on house block 6, were not yet fully embedded and needed ongoing monitoring to ensure they became fully effective. Both reception and first night staff were aware of potential risk factors. There were first night interviews with all prisoners... Insiders (peer prisoners who offer support) were an integral part of the first night procedures. They worked collaboratively with offender management unit (OMU) staff on house block 6 to support prisoners on their first night in custody.”

Previous deaths at HMP Hewell

20. There have been four previous deaths at Hewell in the past year. The investigator reviewed the Ombudsman’s reports into these deaths and she found no issues in common between the earlier deaths and that of the man.

Performance rating

21. Prisons in England and Wales are assessed for performance by the National Offender Management Service (NOMS). For public prisons, NOMS use a combination of the Prison Performance Assessment Tool (PPAT, which looks at 33 indicators) and the public prison weighted scorecard (which looks at a set of 44 indicators). Each establishment is then given a rating between one and four; 4 = Exceptional performance, 3 = Good performance, 2 = Requiring development, 1 = Serious concerns. For the last four published performance reports, HMP Hewell has been given a rating of 3.

Person Escort Record (PER)

22. This is a form that accompanies prisoners on all journeys from and between prisons, police and court. It serves as a communication tool about risks a prisoner poses on escort or transfer. It also provides a chronological record of the escort, e.g. meals served, times journey started etc.

Cell Sharing Risk Assessment (CSRA)

23. All prisoners are subject to a Cell Sharing Risk Assessment (CSRA) on reception. The CSRA process is designed to assess the risks posed by an individual to other prisoners which includes taking into account any previous violence or mental health issues. An assessment takes place before a

prisoner spends their first night in custody and triggers a plan to minimise risk for those identified as high risk which is reviewed at regular intervals.

Induction

24. Induction is the process of introducing new prisoners or newly sentenced prisoners into custody. It is designed to:
    - explain the immediate consequences of being in custody
    - explain the routines of the prison
    - explain the rules and regulations they must observe
    - explain the procedures governing certain processes, such as obtaining visits
    - offer practical advice on obtaining goods and services; and
    - help prisoners understand how to navigate their way around issues of imprisonment.

KEY EVENTS

25. The man was born in February 1947 and, prior to his remand in custody, resided alone in the Solihull area of the West Midlands. He had no previous experience of prison. His friend told my FLO that he spent all of his time and money caring for his sheep.

26. Initially, he was held in police custody on 9 February following his arrest. A risk assessment was completed by the police custody officer at the police station, and he indicated that he had no physical or mental health issues. The Person Escort Record (PER) shows that he was taken to hospital on 10 February, as he was refusing to eat and drink. A discharge letter from the hospital completed by a doctor recorded the diagnosis as food refusal. It said that he had accepted food and drink and returned to police custody the same day.

27. There is also a note to say that he said he suffered from colitis (inflammation of the colon causing pain and diarrhoea) and had prescribed medication for this condition. This is the first mention of any health issue but there is no record that this was confirmed with his GP or that he had medication in his possession. The PER simply stated that he had "two bags of property".

28. He appeared at Magistrates Court on 11 February 2011. He was committed for trial at Crown Court for offences of possession of a firearm, and remanded into custody.

29. Upon entering HMP Hewell on 11 February, Nurse A completed an initial healthscreen. He did not disclose any mental health problems, but said that stress had caused him to have an upset stomach. He told the nurse he had been prescribed loperamide (a medicine used to treat diarrhoea) for this condition, but otherwise he was physically healthy. She described him as 'unshaven, hair unwashed, generally dishevelled and looks uncared for' and referred him to the prison doctor. She recorded that he had a "bag of medication brought into reception, all out of date". There is no entry detailing what these medications were. During interview with my investigator, she said "I didn't document it unfortunately. But they were all out of date [over the counter pain killers] because I remember looking and there was also an empty vial of antibiotics for sheep". In response to the specific reason for the referral to the prison doctor:

> "Flagging up was a bit of irritable bowel syndrome for me, just saying diet, a bit of stress and this sort of thing; so just to get a diagnosis and if he [the man] needed any prescription. The difficulty you've got here is if he decided he'd got an upset stomach one day, it's very difficult to get a prescription that quickly. So if the GP is seeing him and decided he needed a prescription it was there if he needed it."

30. During the reception process, a cell sharing risk assessment (CSRA) was completed. This assesses the level of risk of each prisoner seriously assaulting or killing their cellmate. He had indicated that he 'struggles with

enclosed spaces' and he was assessed as potentially appearing vulnerable due to his appearance. Therefore he was allocated to a single cell on the induction unit.

31. Following his reception and health interviews, he was taken to cell B1-25, on houseblock 6 (the induction unit). This was the only cell in which he resided. Officer A completed a First Night and Induction Plan document with him. This process is designed to elicit information from a prisoner about their personal circumstances, including details about their health, next of kin and any issues that may be relevant to their time in custody. It provides the prison with an opportunity to highlight any potential risk issues or concerns. All new prisoners are offered advice about the prison regime and how an individual can access support if they need to. He stated during his interview that he had no family and friends, was depressed, but had no thoughts of deliberately hurting himself. It was also noted that he, like all new prisoners, had spoken to a Listener in reception. (Listeners are trained by Samaritans to provide confidential emotional support to fellow prisoners.)

32. The following day, he was examined by Prison Doctor A. His blood pressure was 131/65 (normal blood pressure is regarded as being within 90/60 and 120/80) and weight 79kg. He did not raise any medical concerns and was told to seek advice if he needed to.

33. On 14 February, a Community Psychiatric Nurse (CPN) entered on his electronic medical record 'discharge letter to unknown recipient'. There are no other details or reference to a contact regarding his mental health. Following a telephone conversation with the healthcare manager, she confirmed that this was an automated entry generated when the CPN scanned onto the system the discharge letter whilst he was in police custody from A&E "probably as a favour to help out". She said it was not connected to any concern about his mental health.

34. The man was allocated Officer B as his personal officer (a member of staff designated as a first point of contact). During an informal conversation between my investigator and the officer, he said that he did not know him that well and was on annual leave for the week prior to his death. He said that during the time that he knew him, he had "kept himself to himself" on the houseblock. He went on to say that he appeared "lost" and had difficulty finding his way around the unit but was assisted by staff and prisoners in orientating himself. There was no evidence to suggest that he was being bullied, and no evidence that he was taking drugs.

35. It appears that the man did not socialise with other prisoners. The prisoners that spoke informally to my investigator told her that he was very quiet and stayed in his cell. He had no further contact with healthcare staff during his time at Hewell.

Events of 25 February

36. During the night of 25 February at 12.55am, he pressed his cell bell. (The use of the cell bell is restricted for requesting medical assistance or help for another emergency. It sounds in the wing office to alert staff directly to a cell.) Operational Support Grade (OSG) A responded to the cell bell. When he reached the cell, he looked through the flap of the cell and saw him on the floor. He asked for help as he was unwell, but he did not say what the problem was. The OSG said that he looked "panicky and scared" but, as he was breathing, he was conscious and there were no other signs of physical injury. He told my investigator that he did not know him, but that he had checked the wing observation record when he began his duty and there was nothing of concern recorded with respect to him.

37. The OSG reassured him that he would get help and used his radio to request assistance from the Senior Officer (SO), the Night Orderly Officer (NOO) (the designated member of staff in charge of the establishment during the night). No specific emergency code was used, as the OSG stated that he required assistance as opposed to emergency medical help. Officer C, one of the attending officers, also stated that in her opinion, upon arrival at the cell, that it was not a situation that would have prompted a code blue emergency call over the radio (Generally the codes used in emergency situations are 'red' and 'blue'. Blue indicates that a person has breathing/respiratory problems and red that the person is bleeding. The codes allow the medical staff to respond with appropriate equipment).

38. During the night time there is a set protocol for opening cells due to the potential for security breaches. This necessitates breaking a sealed pouch with a cell key, when all other keys are held in a secure location and a senior manager has given authority. Having been told that help would be arriving, the OSG returned to the wing office and used a landline to convey further details to the SO, who checked if there were any specific security risks prior to making a decision to open his cell. His colleague, OSG B, stood outside the cell and gave him reassurance that help was on its way.

39. The SO attended Houseblock 6, along with the assistant night orderly officer, Officer C. On the way, he asked another officer to alert healthcare that assistance was required. This journey is estimated to have taken several minutes, due to the distance between the orderly office and houseblock 6 and the number of gates that needed to be opened, several of which were double locked (an additional security during the night time state). The OSG showed the SO and the officer to the cell on their arrival.

40. Upon reaching the cell, the decision was made by the SO to enter it. However, the man was lying on the floor asking for help and his feet were by the door, blocking entrance. The SO told him he needed to move his feet so they could enter. He moved himself to allow the door to be opened. The officer explained that when the cell door was opened he tried to "shuffle" his way out of the cell. She told my investigator that he had soiled himself, was

disorientated and appeared confused, so she reassured him that healthcare staff were on their way

41. Nurse B and Health Care Assistant (HCA) A responded immediately and attended the houseblock. The man was described as being non-compliant, due to his distressed state, and that it was initially difficult for nursing staff to examine him or take his blood pressure and pulse. This was further hindered by the amount of clothing that he was wearing (five tops in total, although there was no obvious reason or explanation why he was wearing so many clothes) which were cut from him to help the healthcare staff assess him. An electronic monitor was attached to his toe to try to get a blood oxygen reading but this was difficult as he was moving around.

42. His condition then rapidly changed. He began to take deeper breaths and was struggling for oxygen. At 1.20am, an ambulance was requested by the SO, using his radio at the request of the nurse, who also asked for the emergency resuscitation bag to be brought to the cell. This was collected from the healthcare centre by Officer D, although an emergency resuscitation bag was available on houseblock 6. He stopped breathing. No pulse could be found and cardio pulmonary resuscitation was begun. An automated external defibrillator (a portable electronic device that diagnoses rhythms of the heart after cardiac arrest) was attached to him. The nurse told my investigator that it advised not to shock, but to continue with CPR which the nurse did, assisted by Officer C and the HCA.

43. The emergency ambulance was escorted by two officers to houseblock 6 and paramedics arrived at the cell at 1.39am. The paramedics asked staff to continue CPR, whilst they assessed the man. The paramedics gave him a number of drugs to stimulate his heart, but he was pronounced dead at 2.10am. The SO contacted the duty governor to break the news.

44. The duty governor organised a hot debrief (A meeting for staff to discuss issues and any lessons learned following serious events such as deaths in custody. The meeting focuses on reassurance, information sharing and how staff can support each other) but only uniform staff attended. A notice to prisoners and staff was issued the same day by the Governor, announcing the man's death and that support was available via the Listeners Scheme and Care Team respectively.

45. A prison family liaison officer was appointed. The man had not given any details of a next of kin when he entered Hewell so enquiries were made with his solicitor and his friend was identified as a point of contact. The family liaison officer, with a governor and a member of the prison chaplaincy, went to visit the man's friend. Initially, they went to the wrong address and were unable to contact the friend, although at 11.45am they spoke to her on the telephone and were given the correct address. Unfortunately, his friend had already been advised by the police of the death. She was advised of the role of prison family liaison officer, the Coroner and my office's investigation. A letter of condolence from the prison was sent to two friends (another friend had

been identified by his solicitor). The prison offered to assist with the cost of the funeral on 28 February, during a telephone call to the solicitor

46. A post mortem was undertaken on 28 February. He concluded the cause of death was due to chronic obstructive airways disease with evidence of cor pulmonale (right sided heart failure). The toxicology report found no traces of any drugs within his system.

47. The prison arranged for the man's friend to visit the prison on 18 March 2011, when she went to the houseblock and cell B1-25 where he had lived. My investigator confirmed that the friend was shown the correct cell. A condolence card from prisoners was also given to her.

ISSUES

Clinical care

48. The man had no previous experience of prison, and was only at Hewell for 15 days when he died of natural causes. He did not tell staff of any medical conditions or treatment from his GP, other than for an upset stomach caused by stress. He said in reception and during his induction that he was not a smoker, but the post mortem concluded that there was evidence to the contrary.

49. A clinical reviewer was commissioned by the local Primary Care Trust to review the medical care that the man received whilst in prison custody. His clinical review looks at the care and treatment he received at Hewell and measure whether it was appropriate and comparable to that which is available in the community. He and I are satisfied that the care the man received was comparable. He makes four recommendations, which I endorse and have reflected in my own consideration of the issues.

Record keeping

50. Upon arriving at Hewell, the man was in possession of a bag of out of date medication. This medication was not listed and is understood to have been destroyed. During interview Nurse A, who conducted the initial healthscreen, acknowledged that a detailed list of what was contained in the bag should have been made. From her recollection, there was no indication to suspect that he was suffering from any form of debilitating illness or that the medications prompted her to make further enquiries about his health. I do not intend to make any specific comment on individual practice or a formal recommendation but would ask that the Head of Healthcare ensure all staff are reminded of the need to record all medications, irrespective of the expiry date and if they were disposed of.

51. He was at Hewell for a relatively short period of time and he did not disclose any significant medical conditions. During his reception induction he was assessed as potentially vulnerable by prison and healthcare staff, based on his appearance and age. Whilst the assessment of his potential vulnerability is recorded on the CSRA form, the reasons for the assessment have not been made explicit. I do not intend to make a formal recommendation, but would ask that the Governor should ensure that staff completing risk assessment forms record the reason for their assessments to avoid any ambiguity.

52. The initial and secondary healthscreens were completed within the specified 24 hours following his reception at Hewell. However, there were a number of sections that had either not been completed or had not been recorded as having been completed. This can be important in assessing the needs of the individual and on going care.

    The head of healthcare should ensure that both the initial and secondary health screens are completed in full for every prisoner.

The emergency response

53. The prison staff who responded to the man were first aid trained. Particular mention should be given to Nurse B and Officer C for attempting resuscitation along with the HCA in a difficult and confined situation.

54. The clinical reviewer writes of the response:

> "The response to the man on the night he died was expedient and appropriate. There was no delay in starting resuscitation, but there was some delay in getting the defibrillator to house block 6. The staff at the scene made every effort to save his life. Unfortunately this was unsuccessful."

55. Healthcare staff were alerted to attend houseblock 6 following a telephone call from the night orderly officer. No emergency code was used and the 'blue' resuscitation bag (containing amongst general first aid materials, a defibrillation machine and oxygen) was not taken. Following my investigation and interviewing a number of staff, in my opinion it is reasonable that an emergency code was not used, given the man did not present initially as being critically ill.

56. However, following his rapid deterioration, there was a small delay in providing this equipment due to staff being unaware of where this emergency life saving equipment was situated and its accessibility. However, I believe that, in the case of the man, this delay would not have changed the outcome.

The Governor of Hewell should ensure that all staff are made aware of where emergency resuscitation equipment is located.

57. In response to the question raised by the man's friend regarding the injury to his head, during interview Nurse B was unable to recall any specific injury, but told my investigator that the man was 'thrashing around quite a bit' and that 'I just remember entering the room thinking oh my goodness he's going to bang his head'. Given that the injury had not been recorded at any earlier point during his time in custody, it is likely that this is how the bump to his head was sustained.

Access for the ambulance and paramedics

58. The night orderly officer requested an ambulance and immediately detailed staff to escort the ambulance upon its arrival to houseblock 6. The officer who escorted the ambulance was unfamiliar with the route as he was a new member of staff on his first set of nights, although he did take the quickest route. During the cold debrief (a meeting usually within two weeks after a death in custody which provides staff with an opportunity to share experiences and review procedures) staff suggested that an emergency route map was held at the Gate to avoid any future confusion. I do not propose making a recommendation, but is a consideration for the Governor.

59. The paramedics entered houseblock 6 via the lower walkway onto B spur but were hindered by bedding and boxes obstructing the corridor. Whilst in this case it did not significantly delay them attending the man, had they needed to use a stretcher, they would have been more significantly impeded. I understand that this was an issue that was raised during the hot and cold debrief and that the corridor was immediately cleared the same morning. My investigator's observations on her visits were that the corridors were clear. It is imperative that all corridors and walkways are kept clear to ensure that emergency access is not disrupted.

Prisoner support

60. A notice to prisoners was issued by the Governor the same day announcing the death of the man and expressing condolences. This notice reminded them of the available support, via wing staff, the prison chaplaincy and the listeners, although did not detail information on contacting the Samaritans. I do not intend to make a recommendation, but the Governor may wish to ensure that contact details for Samaritans are provided on any future notices.

61. A card of condolence was completed and given to the man's friend when she visited the establishment.

Staff support

62. A notice to staff was issued by the Governor the same day announcing the death of the man which reminded them of the available support, through the Care Team. As outlined also in the report by the clinical reviewer, PSO 2710 (Follow up to deaths in custody) requires:

> 'There must always be a hot debrief immediately after the incident and provision for this should be made in local contingency plans. A senior member of staff must act as debriefer and a duty care team member must also attend'.

63. Whilst this debrief did take place, the nursing staff were not invited to attend. PSO 2710 goes on to say:

> 'Particular reassurance is needed when the prisoner died after unsuccessful resuscitation attempts, when staff involved are more likely to feel a sense of failure. Staff wanting but unable to attend the debriefing should be followed up'.

64. Further, PSI 08/2010 (Post Incident Care) says:

> "The manager responsible must ensure a suitable environment for the meeting, ensure that all staff involved in the incident are invited and given information about the meeting and ensure that staff who wish to attend are released from duty for sufficient time to attend the whole of the meeting."

65. I am concerned that healthcare staff did not attend the debriefs following the man's death. I understand that it was difficult to arrange one inclusive hot debrief due to the time of death and staff having other duties, such as giving statements to the police. However, healthcare staff were integral to the hot debrief and their inclusion should have been a priority. Further, the cold debrief conducted on 29 March, was only attended by prison staff involved, as was the critical debrief facilitated by headquarters staff on 14 April. Those staff who attended the critical/cold debrief described it as "very helpful" to discuss the events with an independent facilitator.

66. Giving staff the opportunity to collectively discuss an incident and reflect on all aspects of how it was managed is fundamental to providing the prison with feedback on any issues that need to be addressed (or indeed good practice). It also provides those directly involved with an opportunity to process events. It is unclear if the Care Team approached any members of the healthcare staff involved. I am disappointed that the experience of support from the prison following the man's death is very different for uniform staff who stated that they felt very well supported, compared to those working in healthcare who did not. Whilst I understand that healthcare staff involved were advised of the employee support telephone line and were informally supported by their peer group, the prison had a duty of care for the well-being of all staff involved.

The Governor of Hewell should ensure that all staff, irrespective of status, position or experience, are provided with formal support from the establishment, following a death in custody.

Other issues considered - Healthcare staff induction

67. This issue had no bearing on the man's case, however I thought it worthy of comment. During my investigator's interviews, a number of the healthcare staff indicated that they had little specific 'jailcraft' training, except key training during their induction period and thought it worthy of comment. Specifically, they had no radio training (including the use of emergency codes) or breakaway technique coaching and were expected to gain their knowledge about working within a prison environment from observing or shadowing more experienced colleagues. Whilst many of the day to day tasks of working in a prison healthcare centre would be learnt in this way, I think it is imperative that all staff, especially those who work directly with vulnerable prisoners in unpredictable settings, are given the tools to safely carry out their duties. Those interviewed felt disadvantaged by the lack of a comprehensive prison induction.

The Governor of Hewell and the Head of Healthcare should review the induction programme for new staff to ensure that they are given essential training to facilitate their safe and effective operation within the establishment.

CONCLUSION

68. I am satisfied that the man was treated appropriately during the time he was at Hewell. I judge that he received care whilst he was in custody which was comparable to that which he could have expected in the community. Indeed, it is possible that he received greater attention than he may have done at the point his condition became critical, given that he lived alone and would not have had the immediate attention that he received.

69. Despite the positive findings in this investigation, I have drawn attention to several procedural issues in this report. However, I do not think that any of these issues would have prevented a different outcome for him.

RECOMMENDATIONS

1 The head of healthcare should ensure that both the initial and secondary healthscreens are completed in full, for every prisoner. A record should be kept of all responses, even if the response is negative or the particular section does no apply to that individual to avoid ambiguity.

Accepted - *The template for the First Reception and Secondary screen are being reviewed and amended to ensure all 'negative' responses are recorded on the system. Target date for completion December 2011.*

2. The Governor of Hewell should ensure that all staff are made aware of where emergency resuscitation equipment is located. Further, consideration should be given to provide all staff with defibrillation training.

Partially Accepted – *Healthcare staff are made aware of the location of resuscitation equipment during induction.*

We will look into the cost/benefits and policy implications relating to the introduction of full staff training in the use of defibrillation training. Completed.

3. The Governor of Hewell should ensure that all staff, irrespective of status, position or experience are provided with formal support from the establishment, following a death in custody.

Accepted – *All staff – irrespective of grade, status, position or experience are provided with formal support following a death in custody. In addition to operational debriefs, critical debriefs are facilitated by Shared Service Centre. However as the majority of staff involved generally work different shift patterns, it is not always possible to catch everyone on the same day. A decision therefore needs to be made to arrange for the debrief when the majority of staff are available. Completed.*

4. The Governor of Hewell and the Head of Healthcare should review the induction programme for new staff, to ensure that they are given essential training to facilitate their safe and effective operation within the establishment.

Accepted – *A review of induction training for all grades of staff working at Hewell will be undertaken. Target date for completion January 2012.*