

**The Death of a Prisoner
at HMP Haverigg
on 7 May 2004**

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

November 2004

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Foreword

This is the report of an investigation into the circumstances of the death of a prisoner at HMP Haverigg on 7 May 2004. It was conducted on my behalf by one of my colleagues in the PPO office.

All deaths of prisoners in custody are investigated, including those due to natural causes. The responsibility for carrying out these investigations traditionally fell to the Prison Service, but has now been passed to the Prisons and Probation Ombudsman to bring independence and greater consistency to the task.

The prisoner was a young man who died suddenly, having shown no signs of impending illness. His death will have been all the more upsetting as a consequence for his family and friends. Indeed, it was his half-brother who actually discovered him on the morning of his death. I would like to express my sincere condolences to all of the man's family for their sad loss. In amongst all this sadness, my investigator uncovered a series of commendable actions by management and staff at Haverigg. His report also includes an important recommendation for the Prison Service as a whole.

STEPHEN SHAW CBE
Prisons and Probation Ombudsman

November 2004

SUMMARY

1. The prisoner was born in 1962 and died at HMP Haverigg on the morning of 7 May 2004.
2. He was serving a sentence of six years and had been transferred from HMP Preston to HMP Haverigg on 29 April 2004, just eight days before his death. His half-brother was also a prisoner at Haverigg.
3. On 5 May 2004, just two days before his death, the prisoner had complained to a doctor at the prison of discomfort at the site of a right hernia repair. Arrangements were being put in place for him to see a consultant surgeon about that matter.
4. At approximately 8.10 am on 7 May 2004, the alarm was raised by the prisoner's half brother, who reported to a prison officer that he thought his brother had suffered an epileptic fit. In response to this information nursing staff and prison officers raced to the prisoner's cell (A2-9) and determined efforts were made over the next 40 minutes to save his life.
5. Paramedics were summoned to the prison at 8.15 am and arrived in the prisoner's cell very quickly at approximately 8.23 am. Regrettably, the combined efforts of the paramedics and prison/nursing staff were unable to save his life. Death was formally certified by a doctor at 9.40 am on the same morning.
6. A clinical review was commissioned from the Medical Director – Primary Care at North Cumbria Primary Care Trust. He concludes that the prisoner's death appears to have been a sudden cardiovascular event confirmed by post mortem findings. The Director finds that resuscitation attempts were carried out in accordance with best practice, that his death could not have been predicted and that the prison staff responded appropriately.

BACKGROUND INFORMATION ABOUT THE PRISONER

7. The prisoner was born in 1962 and at the time of his death he was just 42 years old. He had a number of previous convictions and his prison record indicates he had taken illicit drugs for a number of years. When asked during his Mental Health Reception Screen on arrival at HMP Haverigg if he had any concerns about recent drug issues he replied "No", but referred to daily consumption of heroin and crack cocaine.
8. His final period of imprisonment began when he was received into prison custody as a remand prisoner on 6 February 2002. He subsequently received a six year sentence on 6 September 2002 for a serious violent offence.

9. His prison record indicates that he appeared before the governor at HMP Preston on 27 April 2004 charged with disobeying a lawful order by refusing to go to Reception for transfer to HMP Lancaster on 26 April 2004. He pleaded guilty to the charge and, when asked by the adjudicating governor to explain his conduct, he said:

"I have had two operations and Lancaster is all flights of stairs. I asked to go to Haverigg because it is flat."
10. The prisoner had his wish granted and just two days later on 29 April 2004 he was transferred from Preston to HMP Haverigg. The First Night Risk Assessment document completed on his arrival includes question number 19:

"Do you have any health problems that you have not informed medical staff about, or is there any reason that you feel you need special treatment?"
11. He replied "No" to that question.
12. At question 27 he referred to medical complaints about his knees and at question 28 the officer completing the form expressed no major concerns, observations or issues arising from the interview.
13. The Cell Sharing Risk Assessment completed on 29 April 2004 when he arrived at HMP Haverigg stated that he posed a low risk of harm to other prisoners. He replied "Yes" when asked if he had any concerns about sharing a cell (question 9 on the form) but there is no clear indication as to what these concerns were. The only observation made by the Officer who completed this section of the form was that the prisoner was a smoker.
14. The Health Screening document completed at the same time on reception at Haverigg records the prisoner's painful knees but on the reverse of the form he reported no mobility problems with walking, bending, standing, sitting or lifting. He was fitted for PE at the prison and placed in the top labour category.
15. Both the clinical reviewer and the Healthcare Manager referred to the prisoner's contact with Healthcare Services at the prison on 5 May 2004. On that date, he made an appointment to see the doctor, complaining of discomfort at the site of his right hernia repair. He was seen by Dr B and treated with analgesics. A letter from Dr B referring him to a consultant surgeon at Furness General Hospital following the appointment had already been drafted. However it was still awaiting typing when he died just two days later.
16. Although the prisoner's half-brother thought that the man had suffered an epileptic fit on the morning of his death, the Healthcare Manager has supplied written information to the investigator which indicates that there is no reference in his Inmate Medical Record relating to a diagnosis or history of epilepsy. Nor is there any record of him receiving medication used in the treatment of epilepsy.

INVESTIGATION PROCESS

17. The investigator visited Haverigg on 14 May 2004 when he was briefed by two senior governors and met the governing governor. He read the copious documentation that had been assembled by the prison about the prisoner and the circumstances of his death. The investigator was given a detailed briefing by the Healthcare Manager at HMP Haverigg, and she subsequently wrote to him on 25 May 2004 summarising major events in the prisoner's medical care during the last nine months of his life. The investigator visited A Wing in the company of the Healthcare Manager on 14 May and carefully examined the cell where the prisoner passed away.
18. On 7 June the Family Liaison Officer from my office rang the prisoner's brother to establish whether the family wished to raise any issues. He expressed surprise that there were no traces of drugs in his brother's body at the time of death as the family understood that he might have been continuing to use illicit drugs. This information in turn was conveyed to the clinical reviewer.
19. The clinical reviewer submitted his report on 22 October 2004 once he had received an autopsy report from HM Coroner and concluded that the prisoner's death appeared to have been a sudden cardiovascular event confirmed by post mortem findings. The clinical reviewer reported that the pathologist certified the cause of death as being natural causes due to hypertensive heart disease. The findings on detailed examination showed evidence of heart failure with an enlarged heart. Toxicology reported in the autopsy report showed no evidence of alcohol or opiate drugs at the time of death.
20. The clinical reviewer's professional opinion based on the information made available to him was that the prisoner's death could not have been predicted and that prison staff had responded appropriately. I am very grateful to the clinical reviewer for his expert professional contribution to this investigation.

ESTABLISHMENT PROFILE

21. HMP Haverigg is a relatively isolated establishment located in West Cumbria just outside the town of Millom. It accepts all category C male adult prisoners serving sentences between three months and life, with the exception of those convicted of arson and serious sex offences. The prison's published criteria state that all prisoners should be medically fit as Haverigg does not have 24 hour medical cover and the nearest hospital is 30 miles away. All but a couple of cells on the wing (A Wing) occupied by the prisoner at the time of his death were single cells. Prisoners new to HMP Haverigg are generally held on that wing for two to three weeks while they complete the induction process.

THE EVENTS OF 7 MAY 2004

22. The first indication that something was amiss came at approximately 08.10 am when the prisoner's half-brother walked down the stairs on A Wing from A2 landing to A1 landing and approached Officer Z who was working on the ground floor landing. He said to the officer that he should go and look at his brother who was in cell A2-9. He then told the officer that he thought his brother had just had an epileptic fit.
23. Officer Z immediately ran up the stairs to A2 landing and ran to cell A2-9. When he opened the door he saw the prisoner looking very still "as if he had just come off a fit." Officer Z ran to the medical hatch, which is nearby on the same wing, and told Staff Nurse 1 that she should come immediately as he thought the prisoner had had a fit.
24. According to the officer's statement Staff Nurse 1 promptly dropped what she had been doing and rushed off to cell A2-9. The officer himself locked the gate leading to the medical hatch and ran back to the prisoner's cell in time to hear Staff Nurse 1 asking for an ambulance.
25. Her own statement confirms that at approximately 8.10 am on 7 May she was dispensing medication on A Wing from the treatment room when Officer Z ran over to her. She immediately ran to the cell accompanied by a Senior Officer, followed by two Officers. When she entered the cell she saw the prisoner lying on his back on his bed. He had wet himself, his eyes were fixed and his colour was grey. She immediately requested that paramedics be called.
26. Staff Nurse 1 examined the prisoner and he appeared to take a breath. With assistance from the Senior Officer and the two Officers, he was placed in the recovery position and the Senior Officer cleared his airways. Staff Nurse 1 and the Senior Officer checked for a pulse and, after being unable to find one, commenced CPR (cardio pulmonary resuscitation) at approximately 8.12 am.
27. Once he was placed on his back the Senior Officer started mouth to mouth resuscitation while Staff Nurse 1 did chest compressions. By this time two more officers were present and they assisted the Senior Officer with mouth to mouth resuscitation on a rotational basis.
28. The statement supplied by Staff Nurse 2 times her involvement in the incident as beginning at approximately 8.15 am on 7 May. She wrote that an officer arrived at the Healthcare Centre where she was working at the time and shouted for CPR equipment. Staff Nurse 3 and the Officer obtained the emergency equipment and Staff Nurse 2 took the defib machine (defibrillator). The defibrillator used was an Automated External Defibrillator which issues instructions to staff on the actions they should take to revive the patient.
29. At approximately 8.20 am, when the staff from the Healthcare Centre arrived at the prisoner's cell, Staff Nurse 2 observed that he was lying on his bed

with Staff Nurse 1 carrying out cardiac compressions and an officer using mouth to mouth technique. Staff Nurse 2 switched on the defib machine and shaved the upper right side of his chest to enable good skin contact with the defib pad.

30. The ambulance that had been ordered by Staff Nurse 1 when she first entered the prisoner's cell arrived on the scene extraordinarily quickly. The timings given by staff racing to respond to the emergency are obviously approximate whereas it is reasonable to assume that the timings maintained by the prison's Control Room are extremely accurate. The Control Room log indicates that an ambulance was requested for A Wing at 8.15 am and that the ambulance arrived at the prison at 8.20 am. Staff Nurse 2's account indicates the paramedics arrived at the prisoner's cell at approximately 8.23 am. The paramedics asked if he could be moved onto the floor of his cell. The three staff nurses and two paramedics succeeded in moving him onto the floor using the blanket on which he was lying.
31. For over half an hour, the paramedics and staff nurses made valiant attempts to revive him but regrettably these were not successful. At approximately 9.00 am the medical professionals in attendance agreed to stop CPR because his pupils were dilated and appeared fixed, there was no pulse and there were no signs of respiration.
32. At approximately 9.35am a Doctor arrived on the scene and he certified the prisoner's death at 9.40 am.
33. The Senior Officer's account of his involvement states that at approximately 8.10 am on 7 May he was in his office doing paperwork when he heard Officer Z ask Staff Nurse 1 to attend cell A2-9. He immediately ran to assist and followed Staff Nurse 1 into the prisoner's cell. The Senior Officer records that he tried to establish a pulse but none was present. He confirms that he and Staff Nurse 1 commenced CPR because they noticed that the prisoner's colour had changed and he was going blue. The Senior Officer did mouth to mouth. Several times he checked the prisoner's airway for any obstructions as he could hear bubbling noises, but he records that no obstruction was present or found. The Senior Officer is a trained First Aider whose certificate was issued in September 2002 and is valid for three years.

FOLLOW-UP TO THE PRISONER'S DEATH

34. Prison management at Haverigg were fully aware of their responsibility to notify the prisoner's next of kin in person if that was at all possible. However, the practical difficulty that confronted them was that he had named his partner as his next of kin when he first came into prison custody on 6 February 2002. At that time she was a prisoner at HMP Styal. She is the mother of the prisoner's daughter but, by the time of his death, the relationship had completely broken down. A letter dated 5 April 2004 from her probation officer in Morecambe to HMP Preston (where the prisoner who died was at that time being held) establishes very clearly that he did not

have her mobile number or current address and she was absolutely adamant that he should not have access to that information.

35. After the prisoner's death, his half-brother provided considerable assistance to both the police and prison authorities by supplying detailed information about his family and where they lived. Once it was known that the prisoner's father lived in Morecambe, the prison authorities approached Lancashire Constabulary and asked the police to break the news of his death to his father and/or to his brother. One of the senior governor grades at HMP Haverigg was appointed as Family Liaison Officer and the prison authorities continued during the day of 7 May 2004 to contact the prisoner's father but without success.
36. The first direct contact with a family member came at 5.20 pm on 7 May when the Deputy Governor spoke on the telephone with the prisoner's brother, informing him of the circumstances of his brother's death and where he had been taken. (After the last rites had been said in his cell by Father K, the prisoner was removed from the prison by undertakers at 12.25 pm and taken to the mortuary at West Cumberland Hospital in Whitehaven.)
37. On the evening of 7 May 2004 the prison's deputy governor made contact with the prisoner's former partner and mother of his 12 year old daughter. The next morning she contacted the Deputy Governor to ask for details of the post mortem examination and she was able to confirm at that time that the prisoner's father had spoken to her and informed her of his son's death.
38. On Tuesday 11 May 2004, the Family Liaison Officer and the prison chaplain visited the prisoner's brother and father at their home in Morecambe. Most of the family were present at that meeting and they were invited to visit Haverigg the following week for a memorial service, to see his cell if they wished and to collect his belongings. The prisoner's funeral took place on Friday 14 May and the Family Liaison Officer represented the Governor of HMP Haverigg,
39. The Governor wrote a prompt letter of condolence to the family. On 12 May 2004, she issued a Notice to Staff and a Notice to Prisoners informing them that a short Memorial Service for the prisoner would be held on Wednesday 19 May 2004 in the prison chapel. The service was led by the chaplain with a priest assisting.

FINDINGS

40. The clinical reviewer's expert opinion is that the prisoner's death appears to have been a sudden cardiovascular event. The pathologist certified the cause of death as being natural causes due to hypertensive heart disease. The reviewer further concludes that the records and statements available show that the Healthcare staff responded promptly and effectively when he was found collapsed and resuscitation attempts were carried out in accordance with best practice. The reviewer considers his death could not

have been predicted and that prison staff responded appropriately. He refers to a wider lesson for the Prison Service which is the need to offer prisoners screening for factors that might increase their risk of cardiovascular disease.

41. There was an impressive urgency and commitment in the response of all relevant staff from the first moment that the emergency began. The staff did their utmost to ensure that not a single second was wasted. When the prisoner's half-brother expressed concern to Officer Z about his brother's condition the officer ran from A1 landing to his cell on A2 landing. When Staff Nurse 1 was approached by Officer Z he records that "she promptly dropped what she was doing and rushed off to A2-9". Staff Nurse 1 sent an Officer to the Healthcare Centre to obtain CPR equipment and Staff Nurse 2 reports in her statement that when the officer arrived he shouted for the equipment. When the Senior Officer heard Officer Z report that the prisoner had possibly sustained an epileptic fit he immediately ran from his office to assist Staff Nurse 1.
42. Staff Nurse 1 happened to be issuing treatments on the self same wing where the prisoner was taken ill so she was in a position to reach his cell within just a few seconds of the alarm being raised.
43. Skilled and strenuous efforts were made to revive him in his cell but regrettably these were to no avail. Medical attention was administered by Staff Nurses 1, 2 and 3 and then from approximately 8.23 am by the paramedics who had arrived. The prisoner was given mouth to mouth resuscitation by the Senior Officer and two prison officers.
44. Staff involved in the incident were offered appropriate support on the day by the prison's Staff Care Team and a Critical Incident Debrief (CID) was also organised.
45. Although the prison is in a relatively isolated situation paramedics arrived on the scene extraordinarily rapidly. The control room log indicates they were summoned at 8.15 am, arrived at the prison at 8.20 and entered the prisoner's cell at approximately 8.23.
46. The decision by senior management at the prison to invite Lancashire Constabulary to break the news of his death to his family was appropriate in the circumstances. These circumstances included the fact that contact between the prisoner and his former partner, who was the next of kin he had nominated when first received into custody in February 2002, had broken down by the time of his death. A second relevant consideration is the significant distance between Haverigg and the home of the prisoner's family.
47. The prison demonstrated commendable care and support for his family once contact had been established. A notable example of this is the Memorial Service held in the prison chapel on 19 May.
48. The role played by the prisoner's half-brother in first raising the alarm and then providing family contact details later in the morning of 7 May 2004 was

also commendable. The loss of his half-brother in the circumstances described in this report must have been very hard to bear. I was pleased to learn that he was supported during the day by one of the prison chaplains and follow-up support sessions continued afterwards.

RECOMMENDATIONS

(1) For the Governor

The staff (both medical and discipline) who were most intimately involved in the efforts to save the prisoner's life should receive a letter of commendation. It is for the Governor at HMP Haverigg to decide how many letters should be issued, but there were clearly noteworthy contributions by Staff Nurses 1, 2 and 3; by Officer Z and another, and by a Senior Officer and two further officers, all three of whom administered mouth to mouth to the prisoner.

(2) For the Prison Service

- As part of the sentence planning process, all establishments should check on an annual basis the next of kin details supplied by serving prisoners to ensure that they are still accurate.
- The conclusion of the clinical review is drawn to the attention of the Prison Service. The reviewer states:

“A wider lesson to be learnt from this case for the Prison Health Service is the need to offer prisoners screening for factors that might increase their risk of cardiovascular disease.”