

**Investigation into the circumstances surrounding the death of
a man in hospital in May 2007
whilst in the custody of HMP Stanford Hill**

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

April 2008

This is the report of an investigation into the circumstances surrounding the death of a man at HMP Standford Hill. On the morning of his death, the man collapsed outside the entrance to his wing. He was taken to hospital by ambulance where he was pronounced dead by a hospital doctor. He was 40 years old. The cause of death was a rare form of tuberculosis.

I offer my sincere condolences to the man's family and friends. I must also apologise for the delay in producing this report (this was because the histology report was not received by the Coroner until late November 2007).

The investigation was undertaken by one of my colleagues. We would like to thank the Governor of Standford Hill and his staff for their cooperation. Particular thanks go to the Deputy Governor and the prison's Liaison Officer for gathering all relevant documentation and ensuring it was made available.

A medical practitioner, representing Eastern and Coastal Kent Primary Care Trust (PCT), carried out a clinical review into the care and treatment the man received whilst at Standford Hill. I am grateful to the clinical reviewer for completing the review. I have relied heavily on the clinical reviewer's findings for this report. The main focus of my own investigation has been Standford Hill's response to the man's collapse, and the events following his death.

This was the first death in custody at Standford Hill for many years and I am reassured that the staff and prisoner who responded to the man's collapse did all they could. However, his death highlighted the resource constraints under which the prison was working at the time. It also became clear during the investigation that staff at the prison recognised gaps in procedures for responding to a life threatening situation. I am pleased that the Deputy Governor has already carried out a risk assessment on first aid training, and has laid the foundations for additional family liaison support. An emergency code system was put in place immediately following the man's death.

My report makes one recommendation and makes two commendations. In light of the cause of death, the clinical reviewer notified the Director of Public Health at Eastern and Coastal Kent PCT of the post mortem results.

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Prisons and Probation Ombudsman

April 2008

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SUMMARY

The man was sentenced to four years imprisonment on 6 January 2006. He was sent to HMP Belmarsh. From there, he served a short time at HMP Brixton before settling at HMP Maidstone. Following his progress on a drug dependency programme, and his willingness to enrol on a victim awareness course, he was awarded enhanced status under the Incentives and Earned Privileges Scheme. His continued positive approach at Maidstone led to him being granted category D status, and hence he was able to move to open prison conditions.

The man moved to HMP Standford Hill on 18 January 2007. A full history of his mental health, medical care and drug dependency followed him and this helped the reception healthcare officer (HCO) to carry out an initial screening. The man was referred to a drug advisory service, and the mental health in-reach team. His mental health was to be monitored every four to six weeks by a visiting community psychiatric nurse (CPN). The man generally attended his sessions and spoke openly about how he felt.

For the first two months at Standford Hill, the man appeared to settle well. He did tell his CPN at one session that he missed the discipline and protection that he felt closed conditions at Maidstone had provided, but remained positive and enrolled on three education courses and joined the gym.

At both the art and IT courses, staff began to notice his behaviour change. In February, he was given two Incentives and Earned Privileges warnings for wandering off and failing to return to classes. On his wing, officers and prisoners also became aware of his ongoing mental health problems and his reportedly 'strange' behaviour. The man was monitored by both the drug advisory service and his CPN throughout this time. He was also referred to both services by officers on the wing when he failed mandatory drug tests (MDTs), and when his behaviour caused further concern amongst staff.

In March 2007, the man submitted a complaint against one of the tutors in his art class. An internal investigation did not uphold his claim. At the same time, another memo was sent to the mental health in-reach team about his behaviour on the wing. He stopped going to his education classes and found employment as a wing cleaner.

At no point in the months and weeks leading up to his death did the man seem physically unwell. There is no record of him receiving medical attention for anything other than his mental health and prescription needs. The man's failed MDTs and IEP warnings temporarily lost him his enhanced prisoner status. He regained his enhanced status after working hard as a cleaner and by demonstrating that he was fully compliant with the regime on his wing.

At about 9.15am on the day of his death, and after failing to start work on time, one officer and the wing manager saw the man contorting his body and mumbling to himself. The wing manager sent another memo to the healthcare unit. At 10.20am, the man left the wing and began kicking out at one of two prisoners who were making their way back from healthcare. Witnesses said it was an unprovoked

attack. The man was escorted back to the wing by officers and told to go to his room to calm down.

The man was next seen propped up outside the wing entrance. At about 11.00am, another prisoner was seen talking to him when he fell backwards and collapsed, hitting his head. The prisoner placed him in the recovery position before officers and healthcare staff arrived. The man was given life support until paramedics arrived 20 minutes later. He was transferred to hospital where cardio-pulmonary resuscitation (CPR) continued.

The man was pronounced dead by the hospital doctor at lunch time. The post mortem confirmed that he died from a rare form of tuberculosis. The man did not display any physical symptoms that would have led healthcare staff to refer him for further tests, and his condition had not been diagnosed.

This report includes one recommendation and commends the actions of two members of staff and one prisoner.

THE INVESTIGATION PROCESS

1. On 29 May 2007, my investigator opened the investigation and was briefed about the circumstances leading to the man's death. The investigator requested all prison and medical files in advance of a visit to Stanford Hill on 20 July. At the prison, she met the deputy governor and visited the man's wing. The investigator began the process of identifying the key issues and the staff who had interacted with the man during his time at Stanford Hill. She interviewed a number of prison staff and one prisoner. On a second visit to Stanford Hill on 15 September, she interviewed the deputy governor.
2. A medical practitioner representing Eastern and Coastal Kent Primary Care Trust (PCT), was asked to conduct a review of the clinical care the man received whilst at Stanford Hill. The review was completed and sent to my office on 29 November.
3. The Coroner was informed of the Ombudsman's investigation. The post mortem report concluded that the man's cause of death was as follows:

1a military tuberculosis.

The initial finding of cause of death was delayed pending a histology report. This, in turn, caused a delay in conducting a clinical review of the man's healthcare. The Coroner received the result of the histology report on 22 November 2007 and a copy was forwarded to my office. I am grateful to the Coroner's Officer for sharing this information. At time of writing, the inquest date has not been set. The Coroner will receive a copy of this report to assist with his enquiries.

4. One of my family liaison officers (FLOs) contacted the man's next of kin shortly after the investigation was opened. The FLO explained her role and that of my office, and provided information about the investigation process. She also offered the man's family the opportunity to meet to discuss any issues or concerns. The FLO and a colleague met the man's family at their home. During the visit, the family raised several concerns and asked for further information about certain events. Subsequently, and following the post mortem result, the family asked about a number of clinical issues. These were as follows:
 - Did the man contract (Military) Tuberculosis (TB) whilst in prison? Why was he not diagnosed with this illness in custody before it got to an advanced stage? Why was he not given the opportunity to be treated for the condition?
 - When the man complained of feeling unwell, he was not given sufficient medical attention. He was found outside the healthcare centre three days before he died and all reports indicate that he was behaving strangely in the last few weeks of his life. The man's family want further information on whether his condition was taken seriously.

- Given that he died of a rare form of TB, his family asked whether there were other cases of the disease reported at HMP Maidstone and HMP Standford Hill.

A draft copy of this report was sent to the man's family and the prison service. The family made no further comments on the draft. I will send them a copy of this report. The prison service accepted both the recommendation I make and the commendations. The prison service response can be found on page 25 of this report.

HMP STANDFORD HILL

10. HMP Standford Hill is a category D male resettlement prison and forms part of the Isle of Sheppey 'cluster' of three prisons. Its function is to prepare adult men for their return to the community.
11. Standford Hill was opened in 1950 and has one induction wing (A wing), and two residential wings (B and C), with a total operational capacity of 464 prisoners. All residential wings are single cell occupancy. Prisoners are given 'privacy keys' to their cells and have communal bathroom facilities.
12. Her Majesty's Chief Inspector of Prisons has inspected Standford Hill twice in the last five years. The report she published in 2002 was critical of most areas of the prison. However, when HMCIP returned in August 2004, she commented more positively and reported that significant progress had been made. On arrival at Standford Hill, the reception, first night in custody and induction procedures gave prisoners a good introduction to prison life, and multi-lingual information was now available. Staff and prisoner relations were also good. The lack of a recognised personal officer scheme had been addressed, and staff were generally willing to help and support prisoner needs. In short, around 90 per cent of the recommendations made in 2002 had been achieved within those two years.

Healthcare

13. Standford Hill has a type two healthcare facility, which means health service provision is clinic based and akin to a doctor's surgery in the community. In April 2004, the healthcare centre began the transition to the local Primary Care Trust (PCT). For the next year, the local PCT embarked upon commissioning all health services and conducted an evaluation of the specific needs of the prison's population before introducing NHS policies and procedures.
14. HMCIP complimented the healthcare centre in 2004 for its cleanliness and welcoming staff. The Chief Inspector of Prisons reported that prisoner access to doctors was excellent, and found that most prisoners were seen on the same day they reported sick. In talking to prisoners, without exception inspectors found positive comments about the drop-in approach at the centre, and about the healthcare staff and the care they delivered.
15. The most recent Independent Monitoring Board (IMB) Annual Report on Standford Hill was published in 2006. The report echoed the findings of HM Chief Inspector in relation to healthcare provision. The IMB added that prisoners were seen promptly, but access to the out-patient care facility mirrored the waiting times experienced in the community. However, the IMB was critical of the physical environment in which healthcare was located and highlighted the inappropriate use of a prefabricated building.

Substance use and drug misuse services

16. In her report, HMCIP found that the recommendation she had made in 2002 for officers to form part of the CARAT service (Counselling, Assessment, Referral, Advice and Throughcare) had been achieved. Her 2004 report found that one full time Senior Officer (SO), two Principal Officers (POs) and a CARAT worker were trained and detailed to deliver drugs support services at the prison. In addition, a drugs strategy had been reviewed and updated to better meet the needs of Standford Hill's population. The strategy was led by an SO, responsible for overseeing all drugs services and implementing the changes. HMCIP said that the team in place was enthusiastic and effective. Compared with 2002, prisoners now had good access to the support on offer. Whilst alcohol misuse support had not been given the same focus, the Chief Inspector summed up drugs services at Standford Hill as follows:

“Standford Hill should be commended for its efforts to control substance misuse in the very difficult situation of an open prison.”

Race Relations

17. The Chief Inspector also said that Standford Hill had made encouraging progress in the two years between her inspections. In 2002, the prison faced criticism but, on her return to Standford Hill, HMCIP reported that the newly appointed Race Relations Officer had formed good relationships with prisoners and was committed to this area of work. Her 2004 report commented that prisoners seemed trusting and confident that their concerns would be addressed. However, prisoners perceived that they might be moved to another wing if they made a formal complaint via the internal complaints system. The Chief Inspector said that there was no evidence to support that fear.

Complaints

18. The 2006 IMB Annual Report said that, in the year up to and including 30 April 2005, there were 759 formal complaints, of which 132 were made under confidential access. Both the IMB and the Chief Inspector commented positively on the complaints system at Standford Hill. In 2002, the Chief Inspector had said that, “prisoners should be able to make complaints without obstacles being placed in their way”. This had since been achieved. Her 2004 report found evidence that prisoners generally received timely and helpful replies. Both B and C wing had secure boxes installed and confidential complaints forms had become freely available.

KEY FINDINGS

The man's arrival at HMP Stanford Hill

19. During his time at HMP Maidstone, the man progressed well, particularly with his drug programme and the mental health in-reach team. On 16 January 2007, he was awarded category D status and was considered suitable for transfer to open prison conditions. He transferred to Stanford Hill two days later.
20. When the man arrived at Stanford Hill, he was interviewed by the healthcare officer (HCO) before being located on B wing. His most recent medical history and CARAT referral history from Maidstone were recorded. These told the HCO that the man had received mental health in-reach support every four to six weeks. The man's current medication was listed (Amisopride 200mg, an anti-psychotic drug). He was referred to Stanford Hill's mental health in-reach service and CARAT service. His medical record confirmed that he was fit for transfer and had no outstanding medical appointments.
21. The man settled well on B wing. On 22 January 2007, he completed a Physical Activity Readiness form in order to use the gym. The form stated that he had no physical conditions that would prevent him from using the facilities. The man signed the form and agreed to notify staff of any changes in his physical health. He also enrolled with the Education Department during his induction but, two days later, turned up in the classroom by mistake. An entry in his wing history book set out the problem and confirmed that he could start an information technology (IT) course the following day.
22. On 25 January, the man had his first mental health in-reach assessment. He told the registered mental nurse (RMN), that he had no problem sleeping or eating. The man also confirmed he had started his IT course and was settling in well. Four days later, he had his first CARAT review. The man told his drugs worker that he had not wanted to transfer to Stanford Hill and felt he needed the discipline and protection at Maidstone. His case record for the review on 29 January said that the man admitted using cannabis but appeared stable and did not want further intervention.
23. The man's next appointment with the in-reach team was on 13 February. When he spoke to the RMN, the man said he was collecting his medication weekly and did not have any problems. His care plan said he would be reviewed in four weeks and should continue with his current medication.
24. Throughout the rest of the month, the man attended IT, Art and Spanish classes. His behaviour in class worried staff and he was given two Incentives and Earned Privileges Scheme (IEPS) warnings on 20 and 26 February. The man's wing history book explained that both warnings were for leaving class without permission. Two days later, the man failed a Voluntary Drugs Test (VDT) and was removed from the drug free side of B wing. The VDT officer referred him back to the CARAT team for testing positive for cannabis.

25. On 1 March, the man submitted a formal complaints form. His complaint focussed on his experience in art classes and his relationship with the tutors. The man said that he felt intimidated and bullied, and had heard the tutors use a racist term 'under their breath'. His complaint was submitted to the deputy governor, who in turn, asked the diversity manager, to speak to the man and conduct an internal investigation into his claims.
26. On 3 March, the man's behaviour caused concern again. During mealtime, a B wing officer saw him 'staring into space' at the hotplate for approximately 40 minutes. The officer recorded in the wing observation book that other prisoners on the wing were also worried about his behaviour. Shortly afterwards, the same officer sent a memo to the healthcare centre to inform the mental health in-reach team.
27. The RMN had a conversation with the man on 6 March as a result of the memo. The man said he felt bullied in the art class and told the nurse that he had made a formal complaint about one of the art tutors. The RMN compiled another care plan. This gave the man the next two days off work to 'rest in cell'. The RMN also suggested that he attend his IT class, but not his art class, and booked another review for 8 March. At the review, he told the nurse that he felt much better.
28. On 11 March, the man received a third IEP warning for failing to remain in his art class. He was reported for receiving three warnings in one 28 day period. At his mental health in-reach review on 15 March, the man told the RMN that he had no problems.
29. The diversity manager concluded his investigation into the man's complaint and wrote to the Governor on 22 March. He mentioned in his report that he had interviewed the man, the art tutor and students from the class. His report concluded that there was no evidence to support the man's complaint.
30. The man went to his IT class on 26 March as usual, but was escorted back to the wing by two officers. His instructor rang the wing and said he was very concerned about the man's state of mind and asked for him to be removed. Two wing officers made their way to the classroom, having already informed healthcare. They collected the man and began to make their way back to the wing. En route to B wing, the man walked off towards one of the gates and was asked to stop. When he carried on walking, the first wing officer stood in front of him and held onto his arm. Both officers then took him to the healthcare centre. The first wing officer made an entry in his wing history which said that the principal officer (PO) and the wing SO had been informed.
31. The PO spoke to the man at length and said that he was not to leave B wing until he saw the mental health in-reach team. The PO also spoke to healthcare about the man's behaviour. The doctor confirmed that he was aware of the man's behaviour, but had no immediate concerns about his mental health. An appointment was made for him to see the in-reach team on 28 March.

32. At the appointment, the man was told not to attend education classes any more. The RMN 2, told wing staff that he could remain at Standford Hill and she would contact the induction unit to arrange suitable employment for him. The man's IEPS review took place a few days later. The SO and the officer on duty reviewed his warnings and downgraded his status from enhanced to standard regime. The decision was properly recorded and communicated to staff on the wing.
33. Both staff and prisoners continued to worry about the man's behaviour and he was referred to the in-reach team and the CARAT team again. On 12 April, after prisoners approached the landing officer on B wing, the officer spoke to healthcare. The officer also moved the man to a cell on the first landing to make it easier for staff to monitor him. He saw a drugs worker on 17 April and they discussed his medication. The possibility of arranging for his family to take him on a 'town visit' was also discussed.
34. Following his removal from education classes, the man began working as a wing cleaner. A prison officer completed his first IEPS review assessment since being downgraded. The report said that the man had been fully compliant with the wing regime and was a good worker. The prison officer stressed how hard the man worked and wrote, "I sometimes have trouble stopping him working! Always on time, works hard." As a result of his own efforts, no further positive drug tests and no recent adjudications, he was upgraded to enhanced status at his next review board on 28 April. He was located in a 'self help' cell on the enhanced side of the wing.
35. On the same day, the man got into an argument with another prisoner outside B wing. One of the officers separated them both and recorded the incident in the wing observation book. It is not clear what the argument was about, but the officer said that he felt the argument could continue and informed the wing manager.
36. The man tested positive for cannabis again on 8 May and was referred back to CARAT by one of the officers. At his IEP review board on 12 May, the second wing SO agreed that, despite his positive VDT, the man could remain on the enhanced side of the wing and noted how hard he continued to work as a cleaner.
37. The man did not come to the direct attention of staff again until mealtime on 19 May. The second wing SO and the wing officer observed the man displaying a 'poor attitude' on the wing. The man then brushed past the wing officer and tried to stab the officer with a pen. The wing officer also reported that the man was staring. The officer took the pen from the man and wrote in the wing observation book that staff should be aware of his behaviour.
38. At some point the same week, and during evening roll check, officers noticed that the man was not in his room. Another officer on B wing, told my investigator that she remembered an occasion where the man and a few other prisoners did not return to their cells but could not remember the exact date.

The officer explained that this sometimes happened and was usually the prisoners' way of 'testing the staff a little bit'. The officers filled in IEPS warning forms but used this to get prisoners to comply. The B wing officer told my investigator that, although the man had refused to return to his room, officers had agreed to 'let it go' because they felt his failure to comply with the regime was not deliberate. The officer went on leave and when she returned to work a few days later, the man approached her with his IEPS form. The officer told my investigator that he seemed 'distressed' about receiving the warning. She assured him that it was probably nothing to worry about.

39. The man was charged on 21 May under Prison Rule 61 for being absent from the wing. He was placed on report (adjudication) and his hearing was the same day. The charge against him was proven and he was reduced to half pay for 14 days. He was also told he would lose canteen (use of the prison shop) for 14 days, suspended for six months. There was no corresponding report of the incident in the wing observation book or his wing history sheet.
40. The officer on B wing returned to work on 22 May. She told my investigator that B wing was hectic that day. She recalled that she was supervising the movement of prisoners going to work that morning when the man approached her in the wing office. He seemed distressed that he had been placed on report. She told him that she was too busy to deal with the problem at the time and would speak to him later that day. This was the last time she saw him.

Friday 23 May 2007

41. The employed prisoners on B wing went to work as normal that morning. The man remained on the wing and was expected to start work as wing cleaner. At approximately 9.15am, the duty officer noticed him walking around in circles on the first landing. She spoke to him but he did not reply. The officer recorded his behaviour in the wing observation book and mentioned that the man had not been taking his medication, but it is not clear how she knew that. The officer telephoned the wing manager and reported that the man was acting strangely. The wing manager made his way to the landing and spoke to the VDT officer on the way. The officer repeated the concerns about the man's behaviour and reported that he was not doing his job as wing cleaner.
42. Both the wing manager and the VDT officer found the man on the first landing. The wing manager said that he saw the man 'contorting his body'. When asked if he was okay, he gave a 'mumbled response'. The man then said that he could not start work because he did not have any mop handles and was escorted by the VDT officer to get some from storage. At around 10.00am, the wing manager telephoned the healthcare centre to report the man's behaviour. He filled in a memo and referred the man to a member of the mental health in-reach team.
43. One of the prisoners on B wing, prisoner A, was working in the prison gardens that morning. He took his tea break at approximately 10.10am and, in his statement to police, said he started walking towards the healthcare centre.

He was turned away and told to come back when he had a movement sheet permitting him to walk to healthcare unaccompanied. Prisoner A began the walk back and met another prisoner, prisoner B, coming the other way. As they passed A wing together, they noticed the man on the other side of the road.

44. The man walked towards them, shouting as he approached. Prisoner A could not understand what he was saying. He asked the man if there was a problem and heard him say, "You know, you know." Prisoner A said in his police statement that he knew the man had mental health problems and did not think he was being serious at first. As he shouted at Prisoner A, the man started to kick out. Prisoner B told my investigator that it looked like a 'kung fu' kick but that prisoner A did not retaliate and attempted to get out of the way. The man tried to kick out several times and continued to shout at him.
45. A civilian bricklayer employed by the Works Department at Standford Hill, had just finished some construction work at the administration block. In his statement to the police, he said that at approximately 10.30am he was driving back to his department and passed A wing on the way. As he approached the wing, he saw the man on the steps and prisoner A and prisoner B and walking back from the healthcare centre. His description of what he saw echoes the recollections of the two prisoners. He described how he tried to stop the man from kicking prisoner A by asking him what he was doing. The civilian bricklayer said that the man began to "scream and shout" and did not make sense. The man turned his back on him and walked away with his hands in the air. The bricklayer told the police that the man seemed angry and, as prisoner A mentioned, he did not know if the man was being serious.
46. An officer, who worked in the education department, was walking from A wing back to the education building. At 10.30am, she passed B wing and saw the man walk across the road and through a gap in the hedge. She reported the man's behaviour. In a security form, the officer said his behaviour was 'a bit odd', but she was aware that he had mental health problems.
47. At approximately 10.40am, the civilian bricklayer saw two officers and told them what had happened. The officers followed the man back to B wing and asked him about his altercation with prisoner A. The man told the officers that he thought he was going to be attacked. One of the officers then took him into the wing office, tried to calm him down and told him to go to his room. The man remained outside the office.
48. The wing manager came down to the office to speak to the man and told him again to go to his room. In his incident report, the wing manager said that the man accused the two prisoners of trying to attack him and said that he defended himself by kicking out. The duty officer, the VDT officer and the second landing officer were also in the office and saw the man leave on the instructions of the wing manager.
49. The man went to his room but did not stay there long. The third landing officer said that a few minutes later he saw him leave B wing by the main

entrance and prop himself up outside. Prisoner C, another prisoner from the same wing, was already outside with two other prisoners, rolling a cigarette. He saw the man leaning against the rubbish bin and recalled that he was looking at the floor with his head down, humming to himself. The man agreed to a cigarette and prisoner C rolled another one whilst reading his newspaper.

50. At approximately 10.55am, prisoner D left his cell and made his way to the back field of the prison grounds. He passed the man and prisoner C outside the wing entrance and was about ten feet away when he heard a noise. He turned around and saw the man on the floor. He had collapsed by the entrance to the wing.
51. A number of people saw the man fall backwards to the ground and reported his fall. The second prison officer was one of them and immediately went into B wing's office where he told the wing manager and the other officers. They made their way outside and found that prisoner C had already placed the man in the recovery position. Prisoner C began to talk to him in an attempt to keep him conscious. He also checked for blood because he thought the man had hit his head in the fall. In his police statement, prisoner C said he held the man's head and heard one of the officers from B wing shout, "Do not touch him." The man began to suffer what appeared to be an epileptic fit. Prisoner C noticed that the man's head was getting heavy and told one of the officers. He recalled that an officer got the man a pillow and prisoner C placed it under his head.
52. The wing manager radioed for emergency assistance at about 11.00am. He told my investigator that he spoke to a member of the communications staff, explained that a prisoner had collapsed, and asked for Hotel 1 (emergency healthcare) to attend B wing immediately. The wing manager recalled that the communications officer had some difficulty contacting Hotel 1 by radio and telephoned healthcare to make sure the message was relayed. The HCO was Hotel 1 that day. He received the message at approximately the same time and made his way to B wing.
53. Outside the administration block, the duty governor and the deputy governor had just finished a meeting. As they walked away from the block, the duty governor saw a few people gathered around the man. Both he and the deputy governor approached the area.
54. When the SO based on C wing heard about the man's collapse, he too made his way to B wing and was met by both governors. The SO and the duty governor realised that the man was not breathing and turned him over onto his back. They began CPR. The SO administered breaths without using a protective face mask. The duty governor started 30 chest compressions per minute to the SO's two breaths.
55. Within a couple of minutes, the HCO arrived. In his statement to the police, the HCO said he thought the man had suffered an epileptic fit. He had not brought resuscitation equipment and a defibrillator with him and sent prisoner C back to the healthcare unit for the emergency medical bag. The HCO

checked the man for signs of epilepsy and found no evidence of an epileptic fit. According to the action checklist recording the response to the man's collapse, an ambulance was called at 11.04am. At approximately 11.15am, prisoner C returned to where the man had collapsed with the equipment. During this time, the deputy governor, the SO from C wing, the HCO, the second HCO and the duty SO all took it in turns to administer life support. The second prison officer cleared the area immediately surrounding the man and made sure that prisoners went back to the wing. Staff administering first aid continued for another five minutes, taking it in turns to administer chest compressions and breaths in accordance with the defibrillator's instructions.

56. The deputy governor took overall management control of the response to the man's collapse. She asked the third landing officer to return to B wing and supervise the movement of other prisoners. The deputy governor had already radioed for an ambulance and contacted communications staff another four times to chase its whereabouts. When interviewed about the length of time it took for the ambulance to arrive, the deputy governor explained that there was one paramedic team on the Isle of Sheppey, and that the ambulance had been directed to another emergency. The paramedic left that emergency and came directly to Standford Hill, followed by an ambulance.
57. At 11.20am, the paramedic arrived, shortly followed at 11.35am by the ambulance. The second prison officer directed both vehicles to B wing's entrance. The paramedic asked staff to increase chest compressions to 100 per minute and put an intravenous line into the man. When the ambulance arrived, the man was placed on a stretcher and lifted into the vehicle. Both prison staff and the paramedic continued to administer CPR. The deputy governor asked the second prison officer to go with the man to the hospital. She told my investigator that this was because the man knew the officer, and she thought it would be better for him to see someone he knew if he regained consciousness.
58. An officer from B wing came on duty at lunchtime and saw the ambulance in the prison grounds. She asked a colleague what was happening and was told that a prisoner had collapsed. The officer asked about the identity of the prisoner. She was told it was the man and, when interviewed by my investigator, said that she remembered feeling upset that it was him.
59. The ambulance left the prison grounds at 11.55am. The second prison officer continued chest compressions en route to the local hospital. He also helped the paramedic with an ambu-bag and oxygen. When the ambulance arrived at the hospital at approximately 12.15pm, the officer helped move the man into the resuscitation room and saw hospital staff attempt to revive him. The deputy governor had given the officer a mobile telephone before he left the prison grounds. She then asked the prison chaplain, to accompany her to the hospital and telephoned the man's next of kin to explain that he had collapsed. The deputy governor gave the man's mother the hospital details and arranged to meet his family there. As she was preparing to leave the prison, the second prison officer telephoned. He reported that the man had been pronounced dead by the hospital doctor at 12.45pm.

Events following the man's death

60. The deputy governor spoke first to the second prison officer on her arrival at the hospital. She then met the man's family as arranged and told them that the man had died. She accompanied the man's mother to the hospital chapel and left her in private. The man's family then spoke to nursing staff and asked to see his body. The deputy governor told my investigator that she had to explain that the man's body was still in prison custody and, until released by the police and Coroner, this was not possible. The Coroner's Officer was at the hospital, and the deputy governor told the family that the Coroner would explain the process more fully. The Coroner's Officer spoke to his family again. She explained that she was available at any time if there was anything they wished to discuss. The deputy governor passed on her mobile telephone details and returned to Standford Hill with the second prison officer. The prison chaplain remained at the hospital with the man's family.
62. The wing manager and several other members of staff on B wing ensured that the area where the man had fallen was sealed and evidence preserved for the police and Coroner's arrival. When the police arrived, they took a number of statements from prisoners and staff and photographed the man's cell. In his log of events, the wing manager said that, at 11.57am, the man's cell door was discovered open and was sealed at 11.59am. The SO who was an observer that day, also noticed that the man's cell was not sealed until around 12.00pm.
63. Later that afternoon, staff attended a hot debrief and discussed the response to the man's collapse. As a result of the hot debrief, the absence of a clear emergency code system was identified as were improvements to healthcare preparations for attending emergencies. The same afternoon, two prisoners approached the B wing officer on the wing. The prisoners explained that they wanted to arrange a collection for the man's family. The officer agreed and arranged for collection forms to be typed up and distributed around the prison. The collection was later forwarded to the man's family.
64. The duty governor spoke to prisoner C and reassured him that he had done all that he could to help the man. Prisoner C was understandably shaken by the experience and the duty governor offered him further support if he needed it. Prisoner C requested another visiting order (VO) so that he could have contact with his own family. The wing manager arranged the VO for him. The wing manager also told my investigator that he offered support to his staff on the wing and had been approached by the support team himself.
65. A few days after the man's death, his family were invited by the deputy governor to visit the prison. They spent the afternoon talking to her and to prisoner C, and were escorted to the man's cell by the duty SO. The deputy governor told my investigator that both she and prisoner C answered the man's family's questions as best they could. The deputy governor said it was also helpful to have the duty SO's assistance during the visit. As a trained paramedic before joining the Prison Service, and as the senior officer who

responded to the man's collapse, the duty SO was well placed to accompany the man's family around the prison.

66. The deputy governor contacted the man's next of kin again and discussed funeral arrangements. In accordance with Prison Service Order (PSO) 2710, 'Follow up to a death in custody', she offered to assist with the cost of the funeral and provide ongoing emotional support. At his family's request, no prison staff were present at the funeral. Flowers were sent on behalf of the prison and the deputy governor arranged for prisoner C to attend the funeral (he was released on temporary licence for the service). The man's property was returned to his family afterwards.

ISSUES CONSIDERED IN THE INVESTIGATION

67. The man's death was sudden and unexpected and was the first death in custody at Standford Hill for many years. His collapse tested the prison's contingency plans for responding to an emergency.
68. I believe that staff and prisoners acted compassionately and professionally. However, the sad circumstances also highlighted areas where contingency plans and medical attention could be strengthened. I am pleased to see that the deputy governor and staff at Standford Hill recognised where gaps could be filled and congratulate the management team for implementing changes so speedily after the man's death.
69. That said, my investigation has highlighted one further area where performance could be improved and addresses the issues raised by the man's family. I deal with these below.

Clinical care

70. The man died as a result of a rare physical health condition. (I understand that miliary tuberculosis represents just one to two per cent of all patients with TB.) His medical records overwhelmingly concentrated on his mental health and there was no evidence of him seeking medical attention for any physical symptoms. During his interview with my investigator, the duty governor confirmed that the man had been seen walking towards the healthcare unit on the day he died. That said, the duty governor pointed out that the man did not go into the building and was not booked in to see a member of healthcare staff. The clinical reviewer has found no evidence that the man had sought medical attention in the days leading up to his death.
71. The man had a long term history of drug misuse and had been under regular psychiatric review both in the community and in prison. Approximately nine years before he arrived at Standford Hill, he was identified as someone with mental health needs. In 1998, whilst on remand at HMP Belmarsh, he was diagnosed with paranoid schizophrenia. When released, he continued to receive support from his local mental health service but did not always comply with his treatment.
72. When he came into contact with the criminal justice system again, he was supported by the mental health in-reach teams at HMP Brixton, HMP Maidstone and HMP Standford Hill. When he transferred to Standford Hill, his mental health was monitored by a CPN every four to six weeks. Throughout his whole period of imprisonment, the man was also in touch with the CARAT team.
73. In terms of his medication, the man was prescribed anti-psychotic drugs to help control his mental health problems. When he first came into custody, he was already being prescribed Piportil, via an injection, and Procyclidine, a drug to control the side effects of the injection. Whilst in custody at Maidstone, his medication was reviewed and he was prescribed another anti-

psychotic drug, Amisulpride, twice daily which he took orally. The clinical reviewer found that the man's prison prescription charts did not provide sufficient information for him to comment on whether he took his medication reliably. (Administering medication orally instead of intravenously necessarily increases the chances of patients not complying.) However, the man's medical records do not suggest that he was not taking his medication (and, in any event, patients cannot be forced to comply with prescriptions whether they are in the community or a prison environment).

74. The man was not diagnosed with miliary tuberculosis whilst in custody. The clinical reviewer comments that this rare form of the disease is difficult to diagnose without secondary medical interventions. He adds that the man did not appear to display any of the mild symptoms: fever, coughing, weight loss or swollen glands.

75. About a week before he died, the man told a CPN at his mental health review that he was working as a cleaner and going to the gym regularly. He did not seek medical help or raise concerns amongst staff about his physical health. In the clinical reviewer's experience, he would not expect a mental health patient in either the community or prison to be the subject of regular physical checks or routine blood tests or x-rays. In terms of diagnosing the condition, ante mortem, the clinical reviewer suggests that a chest x-ray might have revealed the pulmonary lesions on the man's internal organs. (Lesions are synonymous with miliary TB). In relation to diagnosis of the condition, the Clinical reviewer concludes as follows (I have reworded his words slightly):

"It is my opinion that the man's lifestyle, as a result of his drug habit and his time in Nigeria, would have increased his risk of contracting the disease, two fold. Miliary TB is a chronic disease and more common in African countries. On the balance of probabilities, the man contracted the disease long before he received a custodial sentence."

76. As page 10 of my report notes, the building used by the healthcare unit has been criticised by both the Chief Inspector of Prisons and the IMB. The duty governor told my investigator that the healthcare unit aspired to better mirror a community doctor's practice and adopt chronic disease management provision in future. The duty governor also said that a new, albeit portable, building would be in use in 2008.

77. The clinical review makes no criticism of the primary care the man received. That said, once the clinical reviewer received the post mortem results, the following suggestion was added to the clinical review as a preventative measure:

"It may be a matter for the Prison Health service to consider whether those deemed to be at extra risk of tuberculosis, by virtue of lifestyle, country of origin or countries visited, should have a routine x-ray"

Medical records

78. The clinical review finds that the man's prescription records were incomplete. In addition, the clinical reviewer comments negatively on his medical records in general. Review of the records was also hampered by frequent illegible entries and a lack of continuity in some instances. Record keeping is essential in order to maintain continuity of care for patients. I endorse the clinical reviewer's view and make the following recommendation,

The Head of Healthcare should ensure that medical records are clear, concise and continuous, in accordance with the Nursing and Midwifery Council's guidelines.

Response to a medical emergency

79. When prisoner C and the officers first responded to the man's collapse, they thought he was having an epileptic fit. Police statements taken on the day, and subsequent statements taken by my investigator, mention that his body appeared to be in spasm and he was still breathing. Prisoner C did all he could to make the man comfortable and to keep him conscious until officers and healthcare staff took over. I commend Prisoner C for acting so instinctively to help the man, and for continuing to help staff once CPR was being administered.
80. With no emergency code system in place, the wing manager radioed for emergency assistance in a timely fashion, but somewhat unclearly. The HCO responded to the telephone call via a member of the communications staff, thinking he was attending to a prisoner with epilepsy. He arrived at B wing's entrance without a full emergency medical bag and defibrillator, and sent prisoner C back to the healthcare unit to pick up the equipment. I do not believe that the delay in using an ambu bag and defibrillator would have changed the outcome for the man. Indeed, staff continued to administer CPR whilst they waited for the medical equipment. If the man had collapsed in the street, it is unlikely that the same equipment would have been to hand until the emergency services arrived.
81. Having said that, a code system, commonly used across the prison estate, would have removed any confusion over the nature of the emergency. Reflecting on the response to the emergency, both the wing manager and the deputy governor mentioned that they were familiar with the system at other establishments. The man's death highlighted a gap in Standford Hill's contingency plans, and the need for further medical equipment to be made available throughout the prison. This was raised at the hot debrief that followed once the man was taken to hospital. The deputy governor confirmed to my investigator that a Code Blue (unconscious/not breathing) and Code Red (conscious/bleeding) system was implemented with immediate effect. In practice, this means that healthcare staff now respond with the appropriate equipment according to the Code given via radio. The duty governor confirmed that across the Sheppey cluster of prisons, there are now nine

defibrillators, of which three are held at Standford Hill. Protective face masks have also been purchased and made available on the wings.

82. The response to the man's collapse was generally managed well. In particular, staff recognised the importance of taking it in turns to perform mouth to mouth resuscitation and carry out chest compressions until the paramedic arrived. I do not underestimate how stressful, tiring and, in some instances, how emotionally draining it is for those who carry out CPR for any length of time. I note that the SO from C wing did not hesitate to attend to the man, initially without a protective face mask. The SO's actions were not necessarily good practice but they were instinctive and ensured that life support commenced without delay. This would have been a particularly unpleasant experience, and indeed it left the SO visibly unwell for a short time afterwards. The likelihood of a member of staff finding themselves in this position in future has been significantly decreased now that face masks have been made more accessible. I know that the deputy governor has already commended the SO for his actions. I would like to offer my own commendation for the way the SO responded so quickly and selflessly, and would be grateful if the Governor could pass this on.

First Aid training and Family Liaison

83. When my investigator first visited Standford Hill, it became clear that the prison had a shortage of first aid trained staff. Indeed, in a subsequent report focussing on a later death at the prison, I mention that one of the prisoners was specifically asked to respond to an emergency as a fully qualified first aider. However, in the man's case, the healthcare staff in attendance were first aid trained and the second prison officer, who accompanied the man to hospital, was also an experienced first aider and a firefighter prior to joining the Prison Service.
84. All prison officers are first aid trained when first entering the Prison Service, but many do not receive refresher courses once they qualify. The deputy governor told my investigator that the issue of first aid was raised at the hot debrief. The shortage of first aid trained staff came as a result of the movement of qualified staff following the introduction of the prison cluster in April 2006. The deputy governor said that the redistribution of staff to HMP Elmley and Swaleside was an unforeseen circumstance of clustering the three prisons.
85. Following the man's death, the deputy governor and the management team at Standford Hill conducted a risk assessment of first aid training, family liaison officer (FLO) training and a review of the local contingency plans. They suggested three improvements to training as a preventative measure. These include heart start training for all members of staff, full first aid training for 20 volunteers and IDTS training. In addition, the deputy governor told my investigator that two other members of the management team were on the waiting list for family liaison officer training.

86. I congratulate the deputy governor for her foresight in conducting a risk assessment to ensure that as many lessons as possible were learnt from the man's death. I also commend her for acting as family liaison officer and offering ongoing support to the man's family after he died. As the deputy governor, this was a substantial responsibility to take on. The deputy governor demonstrated both professionalism and sensitivity as a FLO, in addition to her other managerial responsibilities.

RECOMMENDATION AND COMMENDATIONS

The Head of Healthcare should ensure that medical records are clear, concise and continuous, in accordance with the Nursing and Midwifery Council's guidelines.

The prison service accepted this recommendation. In response they said:

All to be trained to use Emis System for Data Entries and the Healthcare Manager to review patient notes to comply with NMC guidelines.

COMMENDATIONS

I commend the actions of all staff but especially those of the SO from C wing and of the Deputy Governor. The Governor and Area Manager will wish to consider if their actions should be further recognised

I commend the actions of prisoner C. The Governor will wish to consider if his actions should be formally recognised too.

The prison service accepted the commendations.