Investigation into the circumstances surrounding the death of a man at HMP Erlestoke in April 2009

Report by the Prisons and Probation Ombudsman for England and Wales

August 2009

This is the report of an investigation into the circumstances of the death of a man in April 2009, while a prisoner at HMP Erlestoke. He was 51 years old at the time of his death from a heart attack.

The man had suffered from heart problems, diabetes, depression, chronic obstructive pulmonary disease (COPD) and epilepsy for a number of years. Despite these difficulties, his death was sudden and unexpected. I would like to offer my sincere condolences to his family as well as to staff and prisoners who knew him well and were touched by his death.

My colleague conducted the investigation. An independent review into the man's medical care was undertaken by a clinical reviewer on behalf of the local Primary Care Trust. I am grateful to him for his valuable contribution. I would also like to thank the Governor of Erlestoke and his staff for their cooperation and assistance with the investigation. In particular, I am indebted to the Head of Healthcare and her staff who provided a very high standard of liaison and the man's personal officer, who gave helpful information about his time on Wessex Unit.

One of the Ombudsman's Family Liaison Officers contacted the man's daughter. She spoke very highly of the care her father received and was grateful to staff for their support following his death.

I make one recommendation relating to record keeping which the prison service has accepted.

My recommendation aside, I agree with the clinical reviewer's conclusion that the medical care the man received at Erlestoke was appropriate and possibly exceeded that which he would have experienced in the community.

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.

Jane Webb
Deputy Prisons and Probation Ombudsman **August 2009**

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SUMMARY

In May 2006, the man was sentenced to five years imprisonment for a violent offence. He began his sentence at HMP Winchester. He entered prison with a number of long term medical conditions, the most serious being heart problems. According to his medical history, he had his first heart attack before he was 40 years old. As well as ischaemic heart disease, he also had a history of chronic obstructive pulmonary disease (COPD), epilepsy and diabetes. He was a heavy smoker and, despite encouragement from healthcare professionals and his own efforts, he was unable to give up smoking.

The man completed his induction on the first day. At that interview, he said he did not have problems with asthma or diabetes, but had suffered with epilepsy all his life. He said he was allergic to the GTN spray given for angina relief. (This was a significant factor in how the prison service managed his angina and explained why he was frequently transferred to hospital to manage his angina safely and successfully.) He also told healthcare staff he had suffered a nervous breakdown in 2004. His medical records showed that he was overweight, had high blood pressure, heart disease and smoked despite advice.

Throughout his sentence, the man was described as polite and conforming to the prison regime. He was trusted by staff and worked as an orderly for the chapel and as a wing cleaner when he was able. He was transferred to Erlestoke on 14 August 2007 to an offending behaviour course. However, he was unable to complete the courses due to his ill health.

Angina attacks and consequent admissions to hospital were a constant feature of the man's life. He was allocated to ground floor cells because of his heart problems. He also underwent a medical procedure to put a stent into his artery. His diabetes was managed through attendance at the diabetic clinic where he was encouraged to give up smoking and plans were made to improve his diet and resume taking exercise. At Erlestoke, he had regular appointments with healthcare staff for his heart problems and COPD.

In November 2007, a prison doctor discussed with the man whether a prison with a 24 hour inpatient facility would be more appropriate for his needs. They agreed that it would be, but he was a category C prisoner and was reluctant to return to a category B prison. (The clinical reviewer takes the view that given the suddenness of the man's collapse, it was very unlikely that a move to a 24 hour healthcare facility would have affected the eventual outcome.)

On 1 February 2008, the man was noted to be depressed and distressed. An urgent referral was made for a mental health review, but staff decided not to initiate monitoring under the Assessment, Care in Custody and Teamwork (ACCT) procedures. (ACCT is a process designed to support and monitor prisoners at risk of self-harm.)

In September, the man applied for category D status to enable him transfer to an open prison closer to his home and receive visits from his family. They had been unable to visit owing to the distance between the prison and their home.

On 1 April 2009 at around 8.00am, two officers were unlocking cells and another officer was handing out milk for breakfast in the servery. A prisoner alerted the officer who was handing out milk that the man had collapsed in his cell. The officer called for assistance and a prisoner went to the wing office to alert a second officer. Neither the second officer nor a SO were able to find the man's pulse. Therefore the SO instructed the second officer to call an ambulance and, together with two nurses, he carried out cardio pulmonary resuscitation (CPR) until a paramedic arrived at 8.45am. At 9.05am, the man's death was confirmed by a doctor.

The man's family were told of his death by the prison Family Liaison Officer and the Governor.

I conclude that the care the man received was timely and appropriate and his death was unavoidable. I make one recommendation in relation to record keeping which the prison service has accepted.

THE INVESTIGATION PROCESS

1. The Ombudsman was notified of the man's death on 1 April 2009. Terms of Reference and notices were issued to staff and prisoners at HMP Erlestoke, telling them that an investigation would be taking place, and inviting those who wished to see the investigator to make themselves known. The investigator requested copies of the core record, medical record, and other records relevant to his time in custody and to his death.

2. The investigator also contacted the Coroner to inform him of the nature and scope of the investigation and to request a copy of the post mortem report. The report was not available during the investigation or before publication of this report. However, the Coroner's officer told the investigator that the man died of ischaemic heart disease. The Coroner has requested a copy of this report upon completion and I am happy to comply.

3. The investigator visited Erlestoke on 12 June 2009. She met the Governor and his staff. She visited Wessex Unit and spoke with the man's personal officer. She also spoke with the Head of Healthcare.

4. A clinical review of the man's medical care was commissioned from the local Primary Care Trust. It was undertaken by a clinical reviewer who considered the clinical care the man received at Erlestoke and spoke by telephone on a number of occasions with the investigator. His clinical review appears as an annex to this report.

5. The man named his daughter as his next of kin. One of the Ombudsman's Family Liaison Officers spoke with the man's daughter. She told the investigator that her father had a "fantastic rapport" with everyone in healthcare. The family have asked for a detailed account of the morning when he died and I have tried to provide it for them.

HMP ERLESTOKE

6. HMP Erlestoke is set on the former grounds of Erlestoke Manor House in rural Wiltshire. It is a category C adult male training prison and the only prison in the county. It has an operational capacity of 470 prisoners located across nine residential units. The average age of prisoner population was younger than the man.

7. He lived in Wessex Unit which holds 68 prisoners of both standard and enhanced status. (There are three levels of status given to prisoners. Enhanced awards additional privileges to prisoners who comply with their sentence plan and show respectful behaviour. Standard status is applied to prisoners who show respectful behaviour but need to work harder on their sentence plan or other aspects of their behaviour. Basic status reduces the number of privileges to a very low level and is given to those whose show poor behaviour and compliance to the prison regime.) A member of the Independent Monitoring Board (IMB) described the unit as "adequate but jaded". He said that necessary maintenance had been left in the past and now been completed by the new governor. HM Chief Inspector of Prisons had criticised some aspects of the accommodation in the past. Wren Unit had been assessed as being in particularly poor condition and closure of the unit was advised. This remains the case.

8. Erlestoke does not have an inpatient facility. Doctors from a local surgery provided medical cover during the day from 8.00am to 6.30pm. Evening and weekend cover was provided by the out of hours service as provided to the community. Healthcare provision and accommodation had improved since the last inspection. The Head of Healthcare described the healthcare department as nearly fully staffed. Interviews with prospective nursing staff were to be held on the afternoon the investigator spoke with her, which would bring the unit to a full nursing complement.

9. In her report of an announced inspection from 28 April to 2 May 2008, HM Chief Inspector of Prisons said that the prison could be commended overall for purposeful activities and resettlement. However, at the time of her inspection, she identified a serious drug problem and a failure to provide basic equipment such as clean bedding.

10. During the investigation the investigator spoke with the member of the IMB who said that matters had greatly improved which had coincided with the change of governor. He advised that a proactive stance had been taken in running the prison and the number of complaints the IMB received had reduced considerably from around six per week to six per month. As an example, he described the general atmosphere of the prison as "far more settled" with clear guidance given to prisoners on how to complain unlike the previous complicated process.

11. This is the third death investigated at Erlestoke, since 2004 when the Ombudsman was given responsibility for investigating deaths in custody and were due to natural causes. Recommendations have been made in the past; but none are relevant to this investigation.

KEY FINDINGS

12. The man was sentenced at Crown Court on 4 May 2006 to five years imprisonment for a violent offence. He was received into HMP Winchester to begin his sentence. This was not his first time in prison.

13. An entry in the wing history sheet records that he completed his induction into the prison on the same day. The personal summary sheet completed by an officer said that he had named his daughter as his next of kin. He described himself as disabled, a smoker and his religion as Jewish.

14. On the same day, the first reception health screen document was completed by healthcare staff. It lacked important information in a number of areas including the name and status of the member of the healthcare individual completing it. Neither did it say whether the man was suitable for normal location and in any cell or whether he should be referred to a doctor for a further assessment. The document showed the basic information he gave to the healthcare officer regarding his doctor's contact details and his health. He said he suffered from a heart condition and had been released from "hospital, Cosham today", suggesting that he had been released from hospital that day, before attending court for sentencing. He said he did not have problems with asthma or diabetes, but had suffered with epilepsy all his life. He maintained he was allergic to the GTN spray for angina.

15. The man revealed that he had suffered a nervous breakdown in 2004 and had received treatment from a psychiatrist. He said that he had not been admitted to a psychiatric hospital but had received help from a psychiatric nurse or careworker while he was in the community.

16. The secondary health assessment carried out on 29 November 2006 recorded that he was overweight, had high blood pressure, heart disease and smoked. The form did not show whether or not he wished help to stop smoking. Throughout his sentence and numerous attendances and admissions to hospital, He was advised to stop smoking by hospital and prison healthcare staff. However, despite attempts and encouragement from staff, he was unable to do so.

17. October entries in the man's wing history sheet say that he was working well as a cleaner and was an enhanced status prisoner.

18. An entry in his wing history sheet on 5 November described him as a quiet man with "some medical problems". Another entry two days later said that he was to be located on the ground floor of the wing because of his heart problems. He obeyed the wing rules and was often seen by staff out of his cell taking gentle exercise.

19. The corresponding entries in the man's medical record for around this time focus on officers' concerns about the pain in his chest and difficulty breathing. In early December, his medical record notes that he returned from an emergency visit to hospital, after complaining of chest pain. A plan is set out in the record but the

abbreviations used do not make the details clear. It was noted that a discharge summary had not been received from the hospital.

20. The man went to the diabetic clinic on 17 November 2006. His condition was monitored through blood tests and smoking cessation and diet were discussed, with a plan that exercise was to be restarted.

21. As an enhanced status prisoner, he became a chapel orderly in January 2007 and continued to do well in prison. While he was complying with prison rules and coping with his sentence on the wing, his medical record gives the impression of an individual who visited healthcare regularly with cardiac and other unrelated problems. His cardiac problems continued and an ambulance was called again in March 2007 after a member of healthcare staff was called to see him in B wing. The healthcare officer noted that he was depressed but had not been prescribed medication for depression at that time.

22. The man underwent a medical procedure on 20 March to put a stent into his artery. (A stent is a tube placed inside a vein or artery to keep it open.) On his return, he asked to be placed in a single cell on medical grounds. In late March, he complained of migraine headaches and was asked by medical staff to record their frequency so his condition could be monitored and a referral made to the doctor if necessary. There do not appear to be any further references to migraines in his medical record.

23. A memorandum dated 29 March 2007 from locum medical officer to the senior officer on B wing confirmed that the man no longer needed to be restricted to ground floor accommodation and was suitable for B wing.

24. By April and following his operation to have a stent, he was described in his medical record as “No more angina. Feeling very well in himself. Very keen to leave this prison and go to Channings Wood.”

25. An entry in the wing sheet dated 19 April said that the man had been “accepted anytime” on transfer from Winchester to HMP Channings Wood. He arrived at Channings Wood on 2 May and went through the first night and induction process. Early on, his heart problems were acknowledged and he was allowed to have a soft chair in his cell on A wing. The wing sheet records that, on 30 May, a transfer application for HMP Erlestoke was completed. (The transfer was specifically for him to undertake an offending behaviour programme to reduce his risk of re-offending.)

26. While awaiting transfer, the man was employed as an induction orderly on 12 June. However, six days later on 18 June, his wing record shows that he was taken to hospital with a suspected heart attack. He returned to the prison the following day with a discharge summary advising on the medication he should take. The medical record highlighted that he had refused an angiogram and did not wish to go to prison healthcare on his return. (An angiogram is performed by injecting a substance that clearly shows the cardiac vessels.)

27. It appears that a few days later, the man changed his mind about the angiogram. Healthcare staff thought the appointment should be made as soon as possible and telephoned ahead to ascertain waiting times. They were informed that the urgency was decided by a consultant but the wait was "never longer than 11 weeks" and so they pressed for an urgent appointment. An appointment was received for 10 July but there is no evidence in the medical record to show whether he attended.

28. Due to the frequency of his admissions to hospital, a letter dated 20 June 2007 was drafted by the Clinical Lead of the Devon Prison Cluster and addressed to the accident and emergency department of Torbay Hospital. The letter had been written to hold at the gate of Channings Wood in the event of out of hours emergency treatment being required. It set out his condition, existing medication and next of kin details.

29. The man transferred to HMP Erlestoke on 14 August 2007 and was located on Wren unit. He underwent a medical reception health screen which included a Prison Service disability assessment. At that interview, he told staff he had suffered five heart attacks and had chronic obstructive pulmonary disease (COPD). He confirmed that he was epileptic but had not had a fit for around eight years and was allergic to the GTN spray for angina. He said he smoked and preferred a single cell as his sleep was disturbed.

30. He had transferred to Erlestoke specifically to undertake an offending behaviour programme. He completed the induction programme for the course on 28 September. However, his deteriorating health impaired his ability to successfully complete the programme and he was taken off the course. The course manager spoke to healthcare about her concerns in mid September and followed this up with an email. She questioned whether he should be returned to Channings Wood as he had failed to complete the course. There is no evidence of a formal response to the suggestion of a return to Channings Wood, but wing sheets record that he felt the programme was too stressful for him. On his behalf she asked staff whether he would be eligible for a disability wage. The response was that a decision would be made once the outcome of his angiogram was known. In the meantime, wing staff had kept him active by allowing him to assist with wing cleaning.

31. Between 11 September and 19 December, the man had numerous appointments with healthcare staff for his heart and COPD condition. Staff monitored and treated him appropriately. However, the investigator was concerned to note that an escort required to take him for a coronary angiogram on 20 November was cancelled as another appointment took priority. This decision had been taken despite the Medical Appointment (Escort Slip) stating that the appointment was a "No. 1 App URGENT (must not be cancelled). His appointment was rearranged for two weeks later on 4 December.

36. On 6 November, the prison doctor discussed with the man whether a 24 hour inpatient facility would be more appropriate for his needs. The man agreed that this would be more suitable, but was reluctant to be downgraded to a category B solely because of his health. He said that he would like to return to Winchester if

possible. The man also anxious about the length of time it took for an ambulance to travel to the prison due to its rural location. A second prison doctor wrote twice to the governor asking for him to be transferred to a prison with a 24 hour in patient facility. (The clinical reviewer has considered this matter in his review which is annexed to this report.)

37. When visited by nursing staff on 1 February, the man presented as being distressed and very low in mood. Healthcare staff made an urgent referral to the mental health team and he was seen two days later by a mental health worker.

38. On 21 September, a prison officer, and also the man's personal officer, made an entry in the wing history sheet. He said that the man had just completed the Victim Awareness course and had told him that he had 11 and a half months of his sentence remaining. During their conversation, the man said he was trying to attain category D status so he could transfer to a prison closer to his home and receive visits from his family. At the time, they were unable to visit as it was too far for them to travel.

39. The officer told the investigator that he had been the man's personal officer for the seven months before his death and knew him well. He said that the man would have told staff if he was ill. He recalled that there was always someone with him. He had a system in place whereby he could bang on the wall of his cell to his friend in the cell next door if he needed help. He said he thought that the man was honest with him if he was feeling down, but put a brave public face on. The investigator was impressed with the officer's commitment to his role as a personal officer when he told her that he had volunteered to undertake the man's hospital bedwatch on five or six occasions because he knew him well. He recalled that the man had discharged himself from hospital on the last occasion he carried out a bedwatch. He thought this was because hospital staff could not find a vein and had to inject him in his toe. This incident gave the officer the impression that there was an element of the man being tired of his ill health and wanting to give up.

40. During 2008, the man continued to experience bouts of chest pain resulting in admissions to hospital. The clinical reviewer has identified that, specifically, in February, July and August 2008, the man had several overnight admissions to hospital because of chest pain. Hospital discharge summaries say that he did not have heart attacks, but repeated bouts of angina combined with muscular chest pain. Troponin tests at the hospital were negative. (Troponins are a group of proteins found in muscle. Heart specific troponins may be detected in the blood between four hours and 14 days after heart muscle damage and is a highly specific and sensitive test for heart attack.) His low mood continued as his health deteriorated. In spite of chest pain on 12 September, he refused to go to hospital. Healthcare staff allowed him to keep oxygen in his cell and informed wing staff. He continued to attend the diabetic clinic and received counselling for depression.

41. The man was encouraged to lose weight and stop smoking. He attended a smoking cessation course on 30 September. He was assisted by nicotine patches and advised to stop smoking within four weeks. However, he found it

too difficult to give up smoking completely. He was also encouraged to take gentle exercise in the gym, but was reluctant to do so.

42. On 3 March 2009, the man went to healthcare because of a chest infection, for which he was given antibiotics. He was also still awaiting the decision on his application for category D status.

Events in April

43. An officer was on duty in Wessex unit at 7.45am. He said that he and another officer unlocked the cells at around 8.00am and the second officer handed out milk for breakfast at the servery. He said he unlocked the first floor landing cells and the other officer unlocked the ground floor cells where the man was located. It appears that when his cell was unlocked, the man got up and prepared himself for work as usual. The prison family liaison log reported that he was wearing his prison work clothes when he was found collapsed in his cell.

44. In his incident statement, a third officer confirmed that he was distributing milk to prisoners at the servery on the wing. He said that at around 8.20am, a prisoner told him that the man was lying on the floor of his cell. He said he looked through the observation panel in the cell door. He saw that the man was already in the recovery position on his right side on the floor facing the bed. The officer called his name as he went into the cell. He then immediately called for medical assistance using his radio. He asked the prisoner to alert staff to the incident and he tried to keep other prisoners away and keep things calm. He said he remembered a Senior Officer (SO) arriving quickly at the cell and so he left.

45. After unlocking the cells, the first officer said that he and the second officer returned to the office where they were kept very busy dealing with queries from prisoners. The third officer remained at the servery. At around 8.20am, a prisoner came to the office and told the second officer that another officer (the third officer) needed him urgently. He said that at around 8.24am while the second officer was gone, he took a telephone call from a nurse asking him why she was needed on the unit. (The Head of Healthcare explained to the investigator that the nurse would have telephoned to ask what equipment she should bring.) The second officer replied that he did not know as both the other officers were out of the office. It appears that the nature of the emergency was not explained to the communication unit and so the nurse did not know what was required. The first officer recalls that the third officer returned to the office “in a rush” and rang the communications department to instruct them to call an ambulance.

46. The second officer recalled that he was in the wing office at around 8.20am when a prisoner came into the office and told him that the third officer needed him urgently at cell 45. (Cell 45 was the man’s cell.) He said he “rushed down to cell 45” and saw the man lying on his right side on the floor. In his statement, he said he tried to feel for a pulse but after 30 seconds, could not feel anything. The third officer had told him that he had already informed healthcare of the emergency by radio. The table was removed from the cell to give more space.

The second officer was told over the radio net that the SO, the Wessex unit duty manager, was on his way.

47. When the SO arrived, the second officer told him he could not find a pulse but that he was not trained in first aid. The SO also checked the man but could find no pulse or sign that he was breathing. The second officer said that the SO told him to get the incident pack, telephone for an ambulance and to get the duty principal officer to Wessex unit as soon as possible. Having given the second officer instructions, the SO said he immediately placed the man on his back and began chest compressions. At that point, two nurses arrived with oxygen and they began cardio pulmonary resuscitation (CPR) until a paramedic arrived at 8.45am. The SO then left the cell.

48. When the second officer returned to the office at around 8.25am, he immediately telephoned the communications office to ask for an ambulance and for the duty principal officer to attend Wessex unit. In his statement, he said he went back to the man's cell with the first aid kit. He was told that this was not what was asked for. He told the healthcare staff that he could not find the incident pack but they did not reply.

49. The second officer remained outside the cell keeping prisoners away. When the Principal Officer (PO) arrived at around 8.40am, he asked the officer to lock prisoners in their cells.

50. In his statement, the PO said he responded to a call asking him to go to the unit. When he arrived, he was directed to cell 45 where he saw two nurses and the SO giving the man CPR. He instructed that all prisoners were to be locked in their cells to enable the emergency response teams to move onto the unit unhindered. The PO said the paramedics arrived and, recognising that the SO had performed CPR for around 30 minutes, he accompanied the SO to a quiet area of the unit where he was able to wash and have a drink. He arranged for a member of the Care Team to speak with him before he went off duty.

51. The Incident log records that the air ambulance was given permission to land on the prison sports field. It landed at 8.54am. The ambulance arrived at 8.46am and at 9.03am the air ambulance was no longer required. The incident log entry says that at 9.05am, the man's death was confirmed by a doctor.

52. The PO said that while prisoners in Wessex unit remained locked in, the staff were relieved by other colleagues. They went to a quiet area to prepare statements and speak to the Care team.

Events after the man's death

53. The Family Liaison Log of Contact records that the Family Liaison Officer arrived on duty at 10.00am on the day the man died. She found his next of kin details and spoke with the police. Both she and the Governor travelled to the home of the man's daughter at 2.30pm where they gave her the news. The Family Liaison Officer log records that she left her contact details with the daughter.

54. The following day, the Family Liaison Officer spoke with the man's daughter on the telephone. She discussed a memorial service and his cremation. His daughter wished to have the opportunity to come to the prison to see her father's cell and attend the memorial service. The investigator spoke with the Governor who said that staff and around 60 prisoners went to the service. The man's daughter and son-in-law attended and were given gifts and cards.

55. The family said they were happy with the care the man had received and did not raise any issues at that stage. The prison chaplain conducted the memorial service as well as his funeral in the community. Prison staff attended and his property was handed to the family on the day of his funeral as previously arranged.

56. One of the Ombudsman's Family Liaison Officers spoke with the man's daughter. She described her father's death as a "tremendous shock" as he was due for release shortly and the family were looking forward to having him home to live with them again. She said that her father had a "fantastic rapport" with healthcare staff at Erlestoke. She said he never complained about his treatment which was in stark contrast to his experience at Winchester where he had been critical of staff.

57. The man's daughter described the prison family liaison as "absolutely fantastic". She mentioned that the family had been invited to attend the prison memorial service on 8 April and it had been very important to them to attend.

ISSUES

Clinical care

58. The clinical review was undertaken by a clinical reviewer of the local Primary Care Trust. He reviewed all the necessary records and discussed aspects of the man's medical care with the investigator. The clinical review acknowledges that the man was a patient with a number of longstanding medical conditions. The clinical reviewer identified ischaemic heart disease as the most serious of these. He had a history of heart attacks, the first when he was under 40 years old. He also had COPD, which the clinical reviewer advised was the result of lung damage due to heavy smoking, a habit which the man had found impossible to give up. He was also known to be epileptic and diabetic although these conditions were controlled with medication. The clinical reviewer concluded that:

> "Sadly, his early death is not unusual in such a patient, and it appears that his medical care was at least as good as would have been available to him if the man had been at liberty during the period of his illness. There are no recommendations to make which could be expected to avert a similar situation in future."

Transfer to a prison with 24 hour healthcare facility

59. The investigator became aware of the frequency of the man's admissions to hospital, the potential impact of this on the regime and the rural location of the prison. The Head of Healthcare explained that he was frequently admitted because he was allergic to the GTN spray which is used to ease angina. She said he had to be sent to hospital for his condition to be managed effectively.

60. The issue of whether the man should have been transferred to a prison with a 24 hour healthcare facility, such as Winchester, was raised in correspondence by a medical officer at Erlestoke. However the investigator could find no record of a response.

61. The clinical reviewer considered whether the man's health needs would have been best met in a prison with 24 hour healthcare facilities and concluded that they would not. He was of the view that the man's transfer request had no relevance to the circumstances of his death as he died suddenly without an opportunity to call for help. Transfer to a 24 hour healthcare facility was discussed with the man who said he was happy to remain at Erlestoke despite his concern about the ambulance response times. On this occasion the air ambulance arrived within ten minutes of the prison making the emergency call regarding his collapse, which seems reasonable in the circumstances.

62. The man was not transferred to a prison with a 24 hour healthcare facility and I am satisfied that it did not affect the outcome on this occasion. However, this may not always be the case and it may be considered an appropriate option in the future where the progress of a medical condition is slow and it is in the patient's best interest.

Evening staffing arrangements

63. The investigator also learned that the man became unwell mainly in the evenings when staffing levels on the wings were low and healthcare cover was provided by an out of hours service. The investigator spoke with wing staff to explore whether they had any concerns about dealing with his frequent bouts of angina and his subsequent collapse. One member of staff said that they were not all first aid trained and only senior officers were trained in first aid and CPR.

64. The investigator raised this issue with the Governor. His response was that a rota system is in operation which ensures that there is always a member of staff on duty who has had appropriate training. In this case, the third officer was first to arrive at the man's cell and was not first aid trained. The SO, who arrived shortly after, started CPR and continued until healthcare staff arrived minutes later.

65. In this instance it was not crucial that the first member of staff on scene was not trained, however in a future incident it might prove to be so. I make no recommendation here as it is acknowledged the current system did not affect the outcome. However, feedback from staff suggests that some would welcome the opportunity of having first aid training to increase their confidence in dealing with medical emergencies if they are first to the incident.

66. The investigator spoke with the Governor regarding the man's collapse. He said he was very impressed by the huge efforts made by staff to save the man's life. The investigator has seen a copy of each Governor's Commendation for Prisoner Care awarded to the two nurses and the SO cited "In recognition of your actions of the 1 April 2009 whereby you made a valiant and sustained attempt to save the life of the man".

Record keeping

67. The records held at Erlestoke are electronic but the quality of the information held is dependent upon the individual recording it. While entries are timed and dated, the status of the individual making the entry is not clear. The prefix of 'Dr' is obvious but it is not immediately clear whether all other staff named on the medical record are medical professionals, administrative staff or visiting clinicians.

67. The investigator found evidence that a hospital appointment for the man to have a coronary angiogram in 2007 was cancelled as another appointment took higher priority. The healthcare administrator told the investigator that one hospital escort in the morning and one in the afternoon were permitted. She said that if an appointment had to be cancelled, she did so following advice from a doctor or a member of the nursing staff. She said the incidence of cancellation in these circumstances was rare.

68. The investigator discussed this issue with the clinical reviewer. He is of the view that in this case it was not critical to the man's care. However, both he and the investigator raised the concern that there is no evidence of the appointment in

the medical record. Neither is there any entry which explains how the decision was made or the circumstances supporting the cancellation.

The head of healthcare should ensure that staff record their professional status when making entries on the medical record and that a record is made of all hospital and other external appointments as well as the reasons for any cancellation.

Emergency codes

68. The investigator noted that nursing staff had to ring the wing office in order to find out the type of emergency she had been called to and the equipment she was expected to bring. The Head of Healthcare confirmed that an emergency code system to alert healthcare to the type of emergency was not in place. She also confirmed that a Governor's Notice dated 10 June 2009 had since been issued telling staff that a code system had been introduced. Staff who are first on scene to a medical emergency are to give a code sign of Code Red for cardiac, respiratory and blood evident emergencies and Code Blue for all other incidents requiring medical assistance deemed urgent but not a medical emergency. I am pleased that action has been taken and, in the circumstances, I do not make a recommendation.

Assessment, Care in Custody and Teamwork monitoring

69. The investigator observed that the concern on 1 February was such that perhaps opening an ACCT document should have been considered. She discussed this with the governor who agreed that, with hindsight, this might have been the appropriate course of action. The investigator also noted an entry in the clinical record said that the man felt comfortable approaching staff when he was experiencing difficulties and on balance staff monitored him and he was rarely left on his own by his friends in neighbouring cells.

CONCLUSION

71. The man arrived in prison with a number of medical conditions. The most serious was ischaemic heart disease. I believe that he was treated regularly and appropriately. However, I endorse the clinical reviewer's comments regarding the standard of care. The investigation found that, in all the circumstances and despite the best efforts of staff, his untimely death was unexpected and unavoidable.

RECOMMENDATIONS

The head of healthcare should ensure that staff record their professional status when making entries on the medical record and that a record is made of all hospital and other external appointments as well as the reasons for any cancellation.

Accepted.