Investigation into the circumstances surrounding the death of a man at HMP Nottingham in April 2010

Report by the Prisons and Probation Ombudsman for England and Wales

January 2011

This is the report of an investigation into the circumstances surrounding the death of a man who died unexpectedly of heart failure in April 2010 at the age of 56 years. He had finished serving a long prison sentence and was detained at HMP Nottingham under the provisions of the Immigration Act 1971.

The investigation was led by one of my colleagues. One of my family liaison officers contacted the man's family and offered them an opportunity to ask questions about his death and to comment on my report. They did not wish to do so.

I am grateful to the clinical reviewer for providing a clinical review of the healthcare offered to the man in Nottingham. I am also grateful to the Governor of HMP Nottingham who acted as liaison for the investigator.

In 2009 eight prisoners died in or shortly after using prison gyms. The man died suddenly and with no warning or previous medical condition and after having been appropriately assessed by PE staff. He received prompt emergency aid from prison staff who were with him when he collapsed. I make one recommendation that the form in use at Nottingham to assess a prisoner's fitness to use the gym is reviewed. In the light of the number of deaths that have occurred in or after using prison gyms, I consider Governors must satisfy themselves that their assessment criteria are sufficiently robust. I also praise the efforts of staff to contact the man's next of kin and inform them of his death.

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.

Thea Walton
Acting Deputy Prisons and Probation Ombudsman **January 2011**

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SUMMARY

The man died aged 56 in HMP Nottingham in April 2010. In 2001 he was sentenced to 11 and a half years for possession of class A drugs with intent to supply. He finished serving this sentence in 2008 but remained in prison detained under the provisions of the Immigration Act 1971.

He transferred to HMP Nottingham on 7 September 2009. His first reception health screen showed he was fit and well with no evidence of any medical condition. He completed a physical activity readiness questionnaire (PAR-Q) form in accordance with PSO 4250 Physical Education.

In October 2009, the man asked to speak to a CARATs worker (Counselling, Assessment, Referral, Advice and Throughcare – CARATs workers offer advice and support in prison in the treatment of substance abuse). He confessed that he had taken Subutex (buprenorphine – an opioid used to treat opioid addiction) illegally on the wing. A urine test confirmed this. He did not wish to take any medication to detoxify from Subutex. A further urine test on 16 November was negative.

On 23 April 2010, he went to the gym. After his session at about noon he complained to staff of chest pains. He was assessed by physical education officers and emergency response staff were called. When they arrived at the gym, he went into cardiac arrest. Staff attempted cardio-pulmonary resuscitation and an ambulance was called. Despite the attempts of staff and paramedics to save him, he was pronounced dead at 12.44pm.

A post mortem examination showed that the man died of ischaemic heart disease. The toxicology report showed that there was Subutex in his system but this was not associated with his death.

I make one recommendation of my own about modification to the PAR-Q form used at Nottingham to assess a prisoner's fitness to use the gym. I also draw the attention of the local PCT to comments made by the clinical reviewer in her clinical review. I highlight the good efforts of the prison's family liaison officer.

THE INVESTIGATION PROCESS

1. I was notified of the man's death on 23 April 2010. The investigation was allocated to an investigator on 26 April. Notices were issued to staff and prisoners at Nottingham telling them that an investigation would be taking place, and inviting those who wished to see the investigator to make themselves known. The investigator wrote to the Coroner and spoke to the Governor at HMP Nottingham.

2. A clinical review of the man's medical care was commissioned from the local PCT. A clinical reviewer undertook the review. Her report appears as an annex to this report. The investigator spoke to the Governor again in his capacity as Drug Services Co-ordinator. She also spoke to a Senior Practitioner in the CARATs team (Counselling, Assessment, Referral, Advice and Throughcare – CARATs workers offer advice and support in prison on the treatment of substance abuse).

3. One of my family liaison officers spoke to the man's son on the telephone. She explained the nature and purpose of this investigation and offered the family the opportunity to share any concerns they had about his death and raise any questions about his treatment in prison. The man's son said that the family did not want to participate in the investigation process or receive a copy of my report.

HMP NOTTINGHAM

4. At the time the man was transferred to Nottingham, it was a local prison serving the courts in the Nottinghamshire area. It held 550 adult male prisoners, approximately 50% of which were on remand. The remainder of the population were either convicted awaiting sentence or sentenced and undergoing assessment before being transferred to a suitable training prison. In February 2010, Nottingham became a community prison holding 1060 prisoners. The physical expansion included a new offender management unit, reception, visits suite, health centre and workshops.

5. There have been ten deaths in HMP Nottingham since the Ombudsman took responsibility for investigating deaths in prison in 2004. I have identified no common themes between these and that of the man.

6. Nottingham was inspected by Her Majesty's Chief Inspector of Prisons (HMCIP) in an announced inspection in February 2010. At the time of writing the report for this inspection is not published.

7. The Nottingham Independent Monitoring Board's report for 2009-2010 made the following comments about foreign national prisoners held in the prison under immigration legislation after the expiry of their sentences:

> "The number of out of sentence prisoners varied between 8 and 26; the reason is that a number of FN [foreign national] prisoners are transferred from training prisons to a local prison at the end of their sentence because of the fiction that they should not be detained with sentenced prisoners.
>
> "The Board believes that FN prisoners are looked after well, largely due to the FN coordinator who is a particularly conscientious officer. He sorts out their immigration status immediately after arrival, makes sure that they have appropriate opportunities for phone calls, letters and interpreters and sorts out the considerable paperwork involved for prisoners awaiting deportation, applying for asylum or appealing."

KEY EVENTS

8. On 7 September 2009, the man transferred to Nottingham from HMP Lowdham Grange. His first reception health screen showed that he had no current or past health problems. His blood pressure and pulse were normal and he was not overweight. He was recorded as a 'light' smoker and examination showed he was not diabetic. He was passed fully fit to work and fully mobile. As part of the induction process he completed a PAR-Q form and was passed fit to use the gym. There is no date on the copy of the form sent to my investigator.

9. On 8 October, he completed an application form and asked to see a member of the CARATs team. Initial contact was made with him on 14 October. He was interviewed by an officer but said that he had changed his mind and did not want to engage with the service.

10. The man spoke to a member of healthcare staff on 29 October, and again asked to see a CARATs worker. He was interviewed the next day by staff but again said he had changed his mind. He told the staff member that he had been taking Subutex illegally on the wing. (Subutex is the brand name for buprenorphine, an opioid that is used to treat opioid addiction.) She contacted the Substance Misuse Team (SMT) and they made an appointment with him.

11. When he attended his appointment in the Substance Misuse Clinic on 2 November he gave a urine sample that showed positive for Subutex. He spoke to the clinical team manager who advised him that he should start a detoxification plan. The man was not sure if he wanted to pursue this because he was not offered the detoxification medication of his choice and the plan was not implemented. On 14 November, he told Nurse A that he wanted to begin detoxification after all. He was assessed by a member of the SMT on 16 November and was noted not to be suffering from symptoms of withdrawal.

12. The man had a urine test on the same day and the result showed negative for all substances. It was decided therefore that he did not require detoxification. There are no further entries in his healthcare or wing records that indicate he was using drugs or was otherwise unwell during the remainder of his time in Nottingham.

13. On 23 April 2010, he went to the prison gym at about 11am. After his session he had a shower. The PEO (Physical Education Officer) A said in his statement to the Governor that the man came to the office at about 11.40m holding his hand to his chest and told him that he had chest pain. He asked him what exercise he had been doing and whether this had happened before, whether he had pain in his arms, felt sick or was on any medication. He replied that that he had used the treadmill and the weight machines and that he did not feel sick, was not on any medication and had no pain in his arms.

14. The PEO told him that he would contact a nurse to examine him. As he walked away to do so, the man said the pain had gone and he did not need a nurse. The PEO told him to come back immediately if the pain returned. A few minutes later, he came back and said the pain had returned. The PEO asked PEO B to call for a nurse and told the man to sit down with his back against the wall.

15. PEO B said he was working in the office in the gym department when he heard the man telling PEO A that he had chest pains. PEO B said that after questioning the man, PEO A asked him to call for a nurse. He rang the control room and asked for Hotel 9 (the code for the radio held by the emergency response nurse). Within a few minutes three nurses arrived in the gym. PEO B said by this time, the man had moved to the changing rooms because he felt nauseous and PEO C had gone with him.

16. PEO C said in his statement that PEO A told him that the man was experiencing chest pain and that Hotel 9 was on the way to examine him. PEO C is a First Aid trainer. He said he spoke to the man and asked him a number of questions about his symptoms and what he had done in his session. While he was talking to him the man said he felt sick and walked to the changing room where the toilets were. He went with him. He said the man was not sick but his condition was getting worse and he lay down on a bench. The PEO said the man was pale and his skin was cold and clammy to the touch. He said he had chest pain on the left hand side close to his armpit. The PEO took his pulse and it appeared normal. At this point Nurse A arrived with two other nurses.

17. Nurse B said that when he arrived in the gym the man told him that he had been exercising on the treadmill when he felt a pain in the left side of his chest. He said he had been suffering from the same pain for the last 20 minutes. The nurse said he asked Nurse A to ring for an ambulance. He described the man as “clammy but coherent”.

18. Nurse B said that the man then suddenly became unresponsive and his breathing became noisy. He was moved on to the floor and he made basic airway, breathing and circulation checks. He said he felt a pulse but it was weak. The nurses and PEO C began cardio pulmonary resuscitation (CPR) using a bag and a Guedel airway (a medical device used to maintain an unconscious patient’s airway by preventing their tongue from blocking it) to give the man oxygen and performing chest compressions. They attached a defibrillator to him. The defibrillator advised shocking on four occasions. In between, these staff continued CPR.

19. The incident log shows the ambulance was called at 12.06pm and arrived at the gate at 12.13pm. The paramedics’ own record shows that they arrived in the changing rooms at 12.22pm to find the man lying on

the floor with staff attempting CPR. They took over from staff and continued CPR until 12.44pm when they pronounced him dead.

20. The prison activated their death in custody contingency plans. The Coroner and police were informed promptly and the police attended the prison. A governor was appointed as family liaison officer.

21. The man had given his next of kin as a friend who lived in Hull. The prison did not have a phone number but the governor and another member of staff visited the address given at 6.40pm on 23 April. They were able to track down the friend at work the same evening, and broke the news of his death to him. The governor rang the friend again on 26 April and the friend confirmed that he did not want to be involved in the funeral arrangements. The man's friend told the governor that he did not think the man had any family in the UK.

22. Nottingham police subsequently informed the governor that the man had an ex-wife and two sons and they gave him the contact details of his ex-wife. The police had told her of his death. The governor spoke to the man's ex-wife on 28 April and to one of his sons on 29 April. The prison offered to contribute financially to the cost of the funeral and the service was arranged by one of the man's sons. Staff would have attended the service but were not told of the date. In July, prison staff personally returned the man's prison property to his son.

23. A post mortem examination and toxicology report showed that the man had taken Subutex prior to his death. The cause of death was given as ischaemic heart disease and severe narrowing of the coronary arteries.

ISSUES CONSIDERED

Clinical care

24. The clinical review at annex 1 contains a complete account of the medical treatment received by the man during his time in Nottingham. The clinical reviewer concludes that his death was not avoidable. He had no history of heart disease and no other conditions that would have increased his risk of heart problems. He was given appropriate and timely care once he was taken ill in the gym. Emergency equipment was immediately available. She commends the prompt and efficient actions of staff in trying to save the man's life.

25. The clinical reviewer makes a number of points about the electronic medical record system, the organisation of information within it and the advantages of summarising medical information from previous prisons and the community. I draw these to the attention of the local PCT.

The man's gym assessment

26. Prison Service Order (PSO) 4250 Physical Education contains guidance for prisons to ensure they provide a balanced and safe physical education (PE) programme. Paragraph 8.2 lists the minimum requirements of a gym induction programme. One of these is:

> "Physical Activity Readiness Questionnaires (PAR-Qs) must be completed for all prisoners on PE induction prior to participating in PE activity and signed by both the prisoner and the member of staff."

27. The man completed and signed a PAR-Q form. He answered 'no' to questions about whether he suffered from a variety of conditions including a heart condition and chest pains. According to the gym manager, if a prisoner answers yes to any of these questions, PE staff check with healthcare staff before passing them fit for physical activity. If a prisoner answers 'no' to all the questions then they are passed fit (unless PE staff have any concerns about their health).

28. There is no requirement in PSO 4250 for PE staff to check with healthcare staff before passing prisoners fit for activity but I know from other investigations that this is the practice in some prisons. In the man's case, if PE staff had confirmed with healthcare staff that he was being truthful about his physical health, he would have been passed fit because he had no history of any of the conditions listed on the PAR-Q. I am satisfied that the procedure for assessing his fitness for exercise was followed appropriately.

29. The copy of the PAR-Q form seen by my investigator did not include a front sheet. At draft report stage the prison alerted me to the fact that this front sheet was signed and dated by a PE Officer on 10 September

2009. I consider that the form may also benefit from including brief guidance for staff about when prisoners should be referred to healthcare colleagues before being permitted to use the gym. I consider this form should be reviewed for reasons of good housekeeping and in the interests of providing an audit trail.

I recommend that the Governor of Nottingham ensures that the local PAR-Q form is reviewed with a view to including brief guidance to staff about the circumstances in which healthcare staff should be consulted about a prisoner's fitness to use the gym. The Governor should satisfy himself that the criteria for using the gym in Nottingham are sufficiently robust.

The National Offender Management Service (NOMS) partially accepted this recommendation at draft report stage and commented:

The Gym Manager & Healthcare Manager will review the PAR-Q Form and devise a simple flow chart on when to refer prisoners for a more thorough health assessment based on the answers given by the prisoner

The prison's response to the man's illness and death

30. PEO A took the man's complaint that he felt unwell seriously and made an appropriate assessment before deciding to call a nurse. When he told him he felt better the PEO told him to come back to him immediately if the pain returned. As soon as he told staff he felt unwell again, medical staff were called for. PEO C is a qualified first aider and Heart Start trainer (a basic life support course previously taught in prisons). At the point at which the man went into cardiac arrest he and three nurses were present with emergency response equipment. The man could not have received more prompt or more expert medical attention.

31. I am pleased to see that the news of the man's death was broken to his listed next of kin in person by Nottingham staff. I am especially impressed that the governor and a colleague travelled from Nottingham to Hull in order to do this. Staff were initially told that he had no family in the UK. When the police informed them otherwise they contacted his family and properly offered to contribute financially to the cost of the funeral. A comprehensive family contact log was kept.

The man's illegal use of Subutex in Nottingham

32. The man twice asked to see members of the CARATs team in October 2009. On each occasion he then changed his mind about engaging with the service. On the second occasion he volunteered that he had used Subutex illegally on the wing. An appointment was made and he attended the substance misuse clinic. A urine test confirmed that he had Subutex in his system. He declined to begin a program of detoxification but later changed his mind. He was interviewed by the substance misuse team manager and found not to be suffering from symptoms of

withdrawal. Another urine test confirmed that he no longer had Subutex in his system. Accordingly it was decided that he did not warrant a detoxification programme. The pathologist's toxicology report showed that he had taken Subutex before he died but this was not thought to have been a contributory factor in his death.

33. I am satisfied that the man's use of Subutex was dealt with appropriately. He was correctly referred to the substance misuse clinic and assessed by a specialist substance misuse nurse. He was offered a detoxification programme and because there was a delay of some two weeks before he agreed to undertake it, he was assessed and tested again. He was showing no symptoms of withdrawal and had no Subutex in his system and was therefore correctly judged to be no longer in need of detoxification.

CONCLUSION

34. The man was an apparently fit and healthy man. There were no indications prior to his death that he was suffering from ischaemic heart disease. The correct procedure was followed for passing him fit for physical activity. When he became ill in the gym he received prompt and expert medical attention. I do not believe that his death was preventable or that more could have been done to save his life. I am impressed with the professional approach by the governor to family liaison in this case.

RECOMMENDATIONS

1. I recommend that the Governor of Nottingham ensures that the local PAR-Q form is reviewed with a view to including brief guidance to staff about the circumstances in which healthcare staff should be consulted about a prisoner's fitness to use the gym. The Governor should satisfy himself that the criteria for using the gym in Nottingham are sufficiently robust.

2. I draw the attention of the local PCT to the comments made by the clinical reviewer about the electronic medical record system and continuity of care.