Investigation into the circumstances surrounding the death of a man at hospital whilst in the custody of HMP & YOI Gloucester in May 2011

Report by the Prisons and Probation Ombudsman for England and Wales

January 2012

The man was 61 years old when he died at hospital in May 2011. He had been admitted to hospital from HMP & YOI Gloucester on 30 April. He underwent surgery but was placed in an induced coma and did not recover. A post mortem report found that he died of multiple organ failure following a large heart attack after he arrived at hospital.

The investigation was completed by one of my investigators. He visited Gloucester to interview staff and prisoners.

Our Family Liaison Officer contacted the man's family to discuss the investigation. The investigator and Family Liaison Officer visited them to discuss their concerns. I would like to extend my condolences to the man's relatives. I know that they have expressed a number of concerns about his welfare. Their responses to the draft report are included in the report.

A clinical review of the medical treatment which the man received in prison was undertaken by a clinical reviewer, who was appointed by the local PCT. He assessed whether the care that the man received in custody was comparable to that he could have expected in the community. I am grateful to him for his assistance. He found the care the man received to be comparable to that which he could have expected to receive in the community.

The man spent three decades in prison. He was serving a life sentence and had spent time in both open and closed conditions. In the last decade, he was prescribed medication to treat angina and cholesterol. Two days before he was admitted to hospital, he complained of heartburn. A nurse performed a scan, which showed no evidence of a heart attack. The doctor prescribed medication for heartburn. A nurse checked him the following night and found similar symptoms. The next morning, 30 April, the healthcare staff performed another scan and found evidence of an abnormal and concerning heart rhythm. He was admitted to hospital and had a major heart attack during the night, from which he never recovered.

We make two recommendations as a result of the investigation, both concerning the use of the electronic patient record system.

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 Ombudsman **January 2012**

CONTENTS

Summary

The investigation process

HMP Gloucester

Key events

Issues

Conclusion

The family’s response to the draft report

Recommendations

SUMMARY

1. The man committed offences of murder, rape and robbery in 1981. He received a life sentence and moved through a number of different prisons over the following decades. In the early 2000s, he received a diagnosis of angina (chest pain or discomfort that occurs when an area of the heart is deprived of oxygen) and was prescribed regular medication for the condition. He was also prescribed medication to lower his cholesterol in early 2009. At the start of 2005, he moved to HMP Leyhill, an open prison. However, at the end of the following year he transferred back to closed conditions at HMP Shepton Mallet whilst the police investigated an allegation against him dating back to the 1970s.

2. The police did not proceed with a prosecution and the man returned to Leyhill in January 2010. After he moved prisons, his prescription for the drug to lower his cholesterol was discontinued without explanation. Staff soon became concerned about his level of honesty and his associated risk to the public after he was found to have fabricated letters from relatives. As a result, he was transferred to HMP Gloucester, another closed prison, for further assessment on 8 October.

3. The man was initially unhappy with the transfer and was briefly subject to self-harm monitoring in the healthcare centre. However, he settled into life on C wing and found employment. He was regularly assessed by a mental health nurse and also managed to stop smoking with the support of the smoking cessation nurse.

4. On 28 April 2011, the man complained of heartburn to a nurse. She performed a scan, which was normal, and referred him to a doctor, who completed a full physical examination. There was no evidence of problems related to heart disease and, on the basis of the tests performed, the doctor diagnosed acid reflux (stomach acid entering the gullet) and prescribed medication to treat heartburn.

5. The next day, the man did not collect his heartburn medication. During the evening, the wing officer asked a nurse to assess him after he pressed his cell bell. He complained of shortness of breath and heartburn. She examined him and the readings she took were very similar to those recorded by the doctor the day before. The nurse gave him his heartburn medication and arranged for him to be assessed by the doctor the next morning.

6. On the morning of 30 April, a doctor assessed the man. A second scan now showed signs of an abnormal and concerning heart rhythm. The doctor consulted a medical registrar at the hospital and arranged for him to be admitted. He was taken to hospital that evening and had a massive heart attack overnight. Despite undergoing a number of procedures, including heart bypass surgery on 5 May, he did not recover and he died in hospital.

7. A clinical reviewer completed a clinical review of the care the man was offered in custody. He found it to be comparable to that which he could have

expected to receive in the community. We make two recommendations as a result of the investigation, both concerning the use of the electronic patient record system.

THE INVESTIGATION PROCESS

8. The investigator was told about the man's death on 9 May 2011. Notices were issued to staff and prisoners at HMP & YOI Gloucester telling them about the investigation process and inviting them to contact my investigator.

9. He liaised with the safer custody manager during the investigation. He visited Gloucester on 11 May to speak to staff and collect paperwork relating to the man's time in custody.

10. The investigator contacted NHS Gloucestershire to commission a clinical review with regard to the medical treatment which the man received in custody. The purpose of the review is to establish whether the care which he was offered in prison was comparable with that he could have expected in the community. A clinical reviewer was asked to complete the review.

11. The investigator and clinical reviewer visited Gloucester on 23 June to interview five members of healthcare staff. The investigator returned to Gloucester on 10 August to interview two members of discipline staff and speak to a prisoner. He spoke to the Governor during both visits and also provided written feedback about the progress of the investigation.

12. The investigator wrote to the local Coroner's office at the start of my investigation to inform them of its nature and scope. HM Coroner will be provided with a copy of my report.

The man's family

13. One of the Ombudsman's Family Liaison Officers telephoned the man's brother (the family member with whom the prison had liaised since his death) on 21 June. She explained the purpose of my investigation and provided an opportunity for him to raise any concerns he had about the care his brother received. The Family Liaison Officer and the investigator subsequently visited the man's brother, sister-in-law, son, sister and brother-in-law on 19 July.

14. The family asked why, after progressing to an open prison, he had been returned to closed conditions. They also questioned why he did not undergo further tests or an angiogram (an examination of the arteries using x-ray techniques) if he had a longstanding diagnosis of angina.

15. During the meeting, the man's family asked my investigator to consider the treatment he received in the days before his admission to hospital on 30 April. They understood that he might have been experiencing symptoms as early as 27 April. They asked why he was given treatment for indigestion on 28 and 29 April when he was eventually admitted to hospital with heart disease.

16. The man's family understood from another prisoner that he might have collapsed on the morning of 30 April. They asked why his transfer to hospital did not take place until lunchtime. They also questioned why the doctor who examined him on the morning of 30 April did not admit him to hospital in an

emergency ambulance. They wanted my investigator to check whether his transfer to hospital was delayed while two officers were found to escort him.

17. The family asked why it took two days for prison staff to tell them about the man's admission to hospital. They understood from staff that the details for his next of kin were out of date.

18. The family received a copy of our draft report. They provided the family liaison officer with their responses, which we have included. We are very grateful for their contribution and thoughtful comments.

HMP & YOI GLOUCESTER

19. HMP&YOI Gloucester is located in the centre of Gloucester. It holds a maximum of 323 men. Some of the prisoners are young offenders.

Healthcare

20. There are eight beds in the healthcare centre. However, the Head of Healthcare told my investigator that prisoners are usually either treated on the wings or sent to hospital if their condition is sufficiently serious. A nurse and a healthcare assistant work in the prison overnight, providing 24 hour healthcare cover.

Her Majesty's Inspectorate of Prisons

21. HM Chief Inspector of Prisons carried out an unannounced short follow-up inspection of Gloucester in August 2010. In his report, he wrote:

> 'In 2007 we found the prison was … poor in the purposeful activity it offered. It is disappointing that inspectors found the performance of the prison had deteriorated sharply at the time of this follow-up inspection.
>
> 'Inspectors concluded that, on the whole, relationships between staff and prisoners were decent and respectful.
>
> 'However, the physical environment was simply degrading.
>
> 'Prisoners told us that health services were reasonable, they could see a doctor within a couple of days of a request and nurses were helpful, in the main.
>
> 'Gloucester is a prison that causes concern. It has deteriorated since our last inspection. It is a very poor physical environment and there is evidence of a downward drift in performance across a range of areas. It needs urgent attention.'

Independent Monitoring Board

22. The most recent annual report published by the Independent Monitoring Board (IMB) at Gloucester covers the year from December 2009 until November 2010. (The IMB at each prison is made up of members of the public who are both independent and unpaid. They monitor the day-to-day life in their local prison and ensure that proper standards of care and decency are maintained.)

23. The Board made the following comments:

> 'HMP Gloucester benefits from thoughtful, innovative leadership that is genuinely concerned to maintain a regime that, within a firm structure, acknowledges legitimate individual needs. Consequently, for the most

part relationships between staff and prisoners are good, with the handling of the most difficult prisoners often particularly commendable. Similarly, despite the pressures stemming from rivalries and anti-social life-styles that some prisoners bring with them, most visitors find the atmosphere on the wings surprisingly benign. These aspects are indicative of a basically well-run prison.

'C Wing: [where the man stayed] Although modifications to the regime of night sanitation have mitigated some of the inherent difficulties, it has been accepted that there is no appropriate alternative to providing 24 hour access to toilet and running water. More generally, the fabric of the wing is in a very poor state, notwithstanding valiant efforts by the works department. Again, though the Prisons Minister recognised (letter 31st July 2010), "… that the problem will only be resolved if C wing is replaced or refurbished", the Board is unaware of any intention so to do within an acceptable timeframe.'

Previous deaths at Gloucester

24. Since the PPO assumed responsibility for investigating deaths in custody in 2004, I have investigated nine previous deaths at Gloucester. Of these, four were the result of natural causes. None of the previous investigations raised any issues which are directly pertinent to the treatment the man received.

Assessment, Care in Custody and Teamwork (ACCT)

25. Assessment, Care in Custody and Teamwork (ACCT) monitoring is started if a prisoner is thought to be at risk of harming himself. The prisoner is interviewed and a plan for his care is drawn up in response to his needs and concerns. The process is ongoing and the document remains open whilst the risk remains. ACCT reviews should be held at intervals commensurate with the risk that the prisoner presents to himself. Any staff who have contact with a prisoner can make entries in the document. The frequency of observations by staff is set out on the front cover, for example, 'hourly'. Staff must check the prisoner at least this often, they should conduct their observations at random intervals and write down all the checks in the ongoing record. Some of the scheduled checks must be 'quality observations', meaning that the member of staff speaks to the prisoner at some length and has meaningful interaction with him in order to gauge his mood and the risk he may present to himself.

Acid reflux

26. Also known as gastro-oesophageal reflux disease (GORD). This medical condition causes acid from the stomach to leak up into the gullet (oesophagus). A drug which reduces the amount of acid made in the stomach is a common treatment.

27. Heartburn is the main symptom. This is a burning feeling which rises from the upper abdomen or lower chest up towards the neck. Other common

symptoms include: pain in the upper abdomen and chest, feeling sick, an acid taste in the mouth, bloating, belching, and a burning pain when you swallow hot drinks. Some people with acid reflux can experience severe chest pain resembling the symptoms of heart disease. They may also experience shortness of breath. The discomfort that acid reflux causes may be made worse if the patient lies down. However, acid reflux symptoms can last for hours, whilst a heart attack happens in a shorter period of time.

KEY EVENTS

28. On 20 July 1981, the man committed offences of murder, rape and robbery. He was arrested within days, charged with the offences and remanded into custody. He pleaded guilty and received a life sentence at Crown Court on 3 March 1982. He was held in HMP Bristol until 1989 before moving to a number of different prisons in the years that followed.

29. More recently, the man moved to HMP Shepton Mallet in July 2002. After two decades in prison, his health had started to deteriorate. He had put on weight and was a long-term smoker. In the early to mid-2000s, he was diagnosed with raised cholesterol, angina (for which he was prescribed glycerol trinitrate or GTN spray to ease the associated pain) and raised blood pressure, for which he was prescribed atenolol (a beta blocker) and aspirin. Although he managed to give up smoking for a time, he started again and was offered advice about how to quit. In May 2004, he told staff at Shepton Mallet that he disagreed with his diagnosis of angina and did not think that he needed to take his medication. He did not undergo any investigative procedures to confirm the diagnosis.

30. The man transferred to open conditions at HMP Leyhill on 1 February 2005. He was granted periods of release on temporary licence to work in the community.

31. On 20 December 2006, the man transferred back to Shepton Mallet whilst the police investigated allegations about offences possibly committed in the 1970s prior to his imprisonment. Ultimately, the police did not proceed any further with the allegations.

32. By March 2007, the clinical record shows that the man had been diagnosed with ‘ischaemic heart disease’ (of which angina is a symptom). From February 2009, a doctor at Shepton Mallet prescribed simvastatin (a drug which lowers cholesterol). His prescriptions for atenolol and aspirin continued alongside repeat prescriptions for simvastatin.

33. The man was granted permission to move back to an open prison and returned to Leyhill on 11 January 2010. He was assessed by a nurse during the reception process. She recorded that he had high blood pressure and was a smoker. She wrote that he had not been assessed by a doctor for some time in order for his medication to be reviewed. She noted that he was prescribed aspirin, atenolol and simvastatin.

34. On 26 January, a doctor assessed the man. He recorded that he had been diagnosed with ischaemic heart disease and had seen a cardiologist in the past (although it is not clear from the clinical record if or when this appointment happened). The doctor continued his prescriptions for aspirin, atenolol and simvastatin. He advised him to stop smoking and increase his level of activity.

35. A doctor assessed the man on 4 March. His blood pressure was normal. The doctor doubled his dose of simvastatin ‘to achieve optimum control’. However, there is no evidence that the prescription for simvastatin continued in any form after Leyhill switched to a different electronic patient record system during the summer.

36. The man was assessed for chest pain by a doctor in July. He said that he thought that his previous diagnosis of angina might be incorrect. He told the doctor that he had tried to reduce his prescription of atenolol but felt anxious if he did so. The doctor decided to continue his prescriptions for aspirin (75mg once a day) and atenolol (25mg once a day).

HMP & YOI Gloucester

37. On 8 October, the man transferred from Leyhill to HMP & YOI Gloucester. He transferred back to closed conditions after staff discovered that he had been lying to them. The Parole Board had previously expressed concern about his level of honesty but had felt that he might be making progress in this regard. However, staff determined that he had falsified letters which were supposed to have come from family members. Given that his original offences involved deception, it was felt that he needed to temporarily return to a closed prison until his level of risk to the public could be further explored through psychological assessment.

38. Before the man travelled, a nurse checked that he was fit to be transferred and recorded that he was not complaining of feeling unwell. When he arrived at Gloucester, he underwent a first night health screening. The nurse recorded that he had experienced chest pain on three days earlier because of increased stress. The nurse wrote that his heart was damaged, something he was apparently previously unaware of. (There is no previous reference to this in the earlier clinical record.)

39. Staff began Assessment, Care in Custody and Teamwork (ACCT) self harm monitoring the same day. The man was anxious about being recalled from open conditions because he thought that he had been progressing towards his eventual release from custody. Staff reviewed and ended ACCT monitoring 24 hours later with his consent once they were satisfied that the period of crisis had passed.

40. Overnight, staff woke the man to give him his GTN spray (which we must suppose he brought with him from Leyhill because there is no evidence that he was prescribed a new GTN spray at Gloucester). A doctor assessed him on 9 October. He recorded that he had recently experienced a lot of stress and was now tearful and depressed. He also underwent a secondary health screening the same day.

41. Although the electronic clinical record at Gloucester does not clearly evidence the man’s continuing prescriptions for aspirin and atenolol, handwritten drug charts show that he continued to receive these drugs.

42. The man spent his first week at Gloucester in the healthcare centre because of his low mood. Staff in the mental health in-reach teams at Leyhill and Gloucester liaised to ensure that he received continuity of care. Staff carried out a post-closure ACCT review with him on 16 October.

43. The man moved into cell 5-09 on C wing on 22 October. He worked as the number one wing orderly. I understand that he was trusted and well liked by staff and prisoners. Staff described him as compliant, polite and respectful. He made tea and coffee for the staff and did some cleaning on the wing. He was an enhanced prisoner under the Incentives and Earned Privileges (IEP) regime. (The IEP scheme is intended to encourage and reward good behaviour. Additional entitlements, such as more visits, can be gained in return for good behaviour. However, those entitlements can be lost if behaviour deteriorates.)

44. The man's mental health was regularly assessed by Nurse A (a mental health nurse). She told the investigator that he fitted in well on C wing and, after his initial disappointment with the move back to closed conditions, had adjusted and settled in well at Gloucester. He told her that he did not want to return to Leyhill. Instead, he wanted to move to a different open prison. He did not have a severe and enduring diagnosable mental illness such as schizophrenia. However, he was prescribed antidepressant medication for the sort of mild depression often associated with a long prison sentence.

45. The nurse thought that the man always looked fit and healthy in the context of prison life, which can cause men serving long sentences to age prematurely and put on weight. He never complained to her about his physical health or mentioned any chest pain, even when he would sometimes become agitated when he disagreed with the psychiatrists who assessed him. Consequently, she commented during interview that his sudden deterioration and death had been a real shock to her.

46. The man's probation officer and a psychologist based at Leyhill both assessed him during the autumn and recommended that he remain in closed conditions until he had undergone psychological assessment and completed any necessary work. In December, the psychologist recommended that he transfer to the therapeutic community at HMP Grendon for further assessment and support.

47. The man was a long term smoker. On 1 January 2011, he gave up with the help of Nurse B (the prison's smoking cessation adviser). She provided him with nicotine replacement therapy and recommended him for the role of number one orderly on the wing. She thought that he would be more likely to stay away from tobacco if his job kept him busy. He made full use of the smoking cessation clinic in January, February and March and successfully quit smoking. He seemed to benefit from his job as an orderly. The nurse noticed that he became more chatty and confident as he settled into his job.

48. The nurse told the investigator that the man benefited from stopping smoking and looked well. Some colour returned to his face. Although he had a long-

standing diagnosis of angina, she said that he never mentioned any chest pains to her or asked for GTN spray. (This was a medication that he had been given in the past but there is no evidence in the clinical record that he either was prescribed it at Gloucester or indeed asked for it. However, we understand that his relatives noticed a GTN spray when they visited his cell after he died, so the situation remains a little unclear.) The nurse commented during interview that he seemed settled at Gloucester and did not appear stressed. She recalled that he was not overweight, was quite active, seemed to keep fit and looked much younger than his years.

49. A SO spoke briefly to my investigator about the man's time on C wing at Gloucester as the number one orderly. He said that he was a very well liked prisoner who was one of the best orderlies C wing had had. He would prepare tea and coffee for the staff, do the washing up and act as a point of contact for new prisoners. The SO did not remember him ever complaining about his health or looking unwell.

50. On 16 January 2011, a nurse assessed the man. He told her that his sputum (mucus that is coughed up from the lower airways) was blood-stained. He said that he got breathless going up and down stairs. He was short of breath whilst talking to the nurse. She planned for a doctor to review his health.

51. Nurse B assessed the man on 19 January, discussed some bruising on his arm with a doctor and advised him to submit an application to see the doctor if he developed any further bruises.

52. The man's proposed transfer to Grendon was considered in February. (His family told the investigator that his solicitor advised him not to agree to the suggested move, although he was keen to transfer.) He did not transfer. Nurse A spoke to him and recorded that he was 'quite happy' about this and was waiting for his review by the Parole Board in April. He did not expect to be released and thought that the Board might ask him to complete further work to address his offending behaviour. (His case went before the Parole Board in April. He was seeking a return to open conditions. He had not been notified of the Board's decision when he died.)

28 April

53. At about 8.50am on 28 April, the man approached the medication hatch and complained to a nurse of 'prolonged periods of heartburn'. He requested Gaviscon (medication for heartburn and indigestion) and said that he had taken this medication 'in the past'. The nurse dispensed 20ml of Peptac (a similar treatment for indigestion) shortly after 11.00am. She also referred him to a doctor.

54. The normal morning surgery had finished when the nurse asked Prison Doctor A to examine the man at about 11.45am. The nurse had already performed an electrocardiogram (ECG) to check his heart rhythm, which gave a normal reading. She showed it to the doctor, who agreed to assess him during an additional, unscheduled appointment.

55. The man described his history of heartburn and reported epigastric (abdominal) pain which got worse when he lay down. He said that he had had similar symptoms for 'a couple of years'. He told the doctor that he had 'pins and needles' in his left arm. The doctor confirmed that he was prescribed aspirin, atenolol and fluoxetine and recorded that he had no current symptoms of ischaemic heart disease. He asked him if he felt sick, sweaty, hot or cold. He said that he did not.

56. The doctor performed a full physical examination whilst the man lay on the couch. His blood pressure was low. The doctor discussed his long-standing diagnosis of angina with him. They agreed that his ongoing prescription for atenolol was doing some good.

57. The doctor prescribed omeprazole to treat a diagnosis of gastroesophageal reflux disease or 'acid reflux' (a condition which causes stomach acid to come up into the gullet). The doctor thought that his diagnosis was consistent with the man's presentation, the ECG reading taken that morning and his previous episodes of heartburn. The doctor checked a previous ECG reading taken in 2009 which had given a comparable and equally normal result. He told the investigator that the man had 'classic symptoms' of acid reflux.

29 April

58. The man did not collect his dose of omeprazole during the day on 29 April. An officer told the investigator that he had felt unwell during the day, stayed in his cell and did not carry out his usual duties as the number one wing orderly. The officer remembered that staff arranged for his dinner to be taken up to him in his cell.

59. Officer A was responsible for managing C wing overnight. He came on duty at 8.30pm. He told the investigator that there were no problems reported during his handover from the day staff. He checked all the prisoners during a roll check without incident. At about 10.00pm, the man pressed his cell bell. He thought this unusual because each cell on C wing has an intercom system which prisoners can use to contact the night staff. The officer knew that he was not a prisoner who abused the cell bell system.

60. The officer spoke to the man using the intercom. He replied in a wheezy voice. He was breathing shallowly and was hard to understand. The officer was concerned and went to the cell. He opened the observation flap and saw him sitting in his chair. He had his hand on his chest and asked the officer to fetch a nurse. He explained that his chest was tight and he was finding it hard to breathe.

61. The officer told the investigator that he could see that the man was unwell, so he telephoned Nurse C and asked her to come over to the wing to assess him. The Senior Officer (SO) (the night orderly officer, who is in charge of the prison at night) and an officer (the assist night orderly officer) escorted the nurse across to the wing because nurses do not carry keys overnight. The

nurse took the emergency bag with her as a precaution because she was unaware of exactly how unwell he might be. She looked at his clinical record before she set off for the wing. She checked the observations (such as blood pressure) that her colleagues had recorded the day before.

62. The nurse assessed the man in his cell whilst Officer A and the two night orderly officers waited by the door. He complained of heartburn and shortness of breath. She checked his pulse (which was strong and regular) and blood pressure, which was 'within normal range' (although still low). Both readings were very similar to the day before when the doctor had assessed him. He did not look unusually pale and did not seem to have trouble breathing whilst talking. The nurse told my investigator that he was 'a good colour' and had no problem moving about. She asked him to raise his arms over his head, which he managed to do.

63. The nurse dispensed the omeprazole that the man should have collected earlier in the day. She explained to my investigator that his 'in possession' seven day supply of omeprazole had not yet been prepared. To begin with, he was supposed to collect a daily dose from a nurse at the medication hatch. However, because he did not like to complain or cause a fuss, he told the nurse that he had been continuing to use his supply of Peptac rather than bother healthcare staff for the omeprazole that the doctor had prescribed the day before. She therefore gave him what was actually his first dose of omeprazole.

64. The nurse advised the man to stop drinking orange juice because it would not help his acid reflux symptoms. She checked that he had plenty of water to drink. She told my investigator that her assessment lasted about twenty minutes. He thanked her when she had finished. She told him to ask for her again during the night using his cell bell if he felt worse.

65. After they had locked the cell door, Officer A asked the nurse if he should keep an eye on the man during the night. She said that he could do so, but that he would probably feel better now that he had taken his indigestion medication. The officer told the investigator that he checked him three more times during the night. On each occasion, the officer checked for movement and found him sitting up in his chair, dozing. When he checked him during the 5.30am roll check, he was still sat in his chair but was awake and acknowledged him. He had a blanket over his legs.

66. The nurse referred the man to be assessed by the doctor the next morning using the electronic patient record system. She made a written entry to this effect on the healthcare communications handover sheet for her colleagues to read the next morning. She also gave a verbal instruction to the nurse starting a day shift on C wing before she went home.

30 April

67. The next morning, a prisoner in the neighbouring cell checked the man at about 9.00am and found him still sitting in his chair. He was pale and did not

find it easy to talk. He went to collect a further dose of omeprazole from Nurse B. He said that the drug seemed to have helped overnight but that his indigestion was still quite bad.

68. Following Nurse C's referral the previous night, Nurse B took the man to the healthcare centre to be assessed at the start of surgery as soon as the doctor was ready. In addition to Nurse C's referral, Nurse B was able to observe a deterioration in his appearance because she had seen him regularly over the last few months. Although he did not complain or insist on an assessment, she was convinced that the doctor needed to examine him.

69. Prison Doctor B assessed the man shortly after 10.00am. Nurse B was present during the consultation. He said that the omeprazole seemed to have helped, but that he was still experiencing indigestion and shortness of breath (even at rest). He said that he had not been able to take full breaths during the night and had experienced discomfort whilst lying down.

70. The man's condition had worsened. The doctor noticed that he looked pale but did not have a fever. His pulse was fast and irregular and his blood pressure low. The nurse performed a second ECG which showed a different result to the first one. She referred him back to the doctor, who checked the results and became concerned.

71. After he had seen the remaining patients waiting in surgery, the doctor telephoned the on-call medical registrar at the hospital. The man went back to his cell to rest whilst the doctor made enquiries because the waiting room was very stuffy and uncomfortable. His cell door remained open. Nurse B went to check him because she was worried that he appeared jaundiced (yellowing of the skin or the whites of the eyes). She remembered during interview that he remained mobile and was still not complaining of chest pains. Rather, he continued to describe his discomfort as indigestion.

72. The medical registrar agreed to assess the man in the accident and emergency department and told the doctor to arrange for him to be taken to the hospital. The doctor told a nurse to request an 'urgent' rather than a '999' emergency ambulance because the ECG provided a different result from two days earlier. His heart rhythm was abnormal and now gave cause for concern. (An 'urgent' ambulance takes a patient to hospital within two hours, rather than straightaway.) The ambulance was requested at 11.55am. A further call to the ambulance service was made at 12.10pm. He continued to rest in his cell until the ambulance arrived at 12.25pm. The ambulance left the prison at 1.15pm.

73. The man was escorted to the hospital by two prison officers. He was handcuffed to one of them using an escort chain. (An escort chain is a length of chain with handcuffs at either end. It allows the prisoner to be restrained whilst also permitting hospital staff to treat the patient without the escort officer getting in the way.) At about 8.00pm that evening, he was taken to the another part of the hospital for further treatment, arriving about an hour later.

74. The man had a ‘sizeable’ heart attack in the early hours of the next morning, 1 May. At about 6.30am, the duty governor agreed to the removal of restraints to allow him to be treated. (Restraints were not used from this point onwards.)

75. A nurse at the hospital asked prison staff to locate and notify the man’s family about his condition because he might not survive his heart attack. The duty governor travelled to the prison to contact the man’s named next of kin. Unfortunately, the information was not clearly recorded in either his prison records or on the P-NOMIS electronic record system. Although a prisoner is supposed to provide up-to-date next of kin details during the reception process at Gloucester, this had not happened.

76. The duty governor and SO consulted the man’s visits paperwork, his telephone PIN records and the ACCT document closed in October 2010. The SO asked the police to visit old family addresses recorded in the paperwork but these were found to be out of date when the police visited them at about 7.00am.

77. Looking through his file, the duty governor and SO initially identified the man’s fiancée as his next of kin. (He had met her in the last few years during periods of release on temporary licence whilst he was held in open conditions.) When the duty governor spoke to her on the telephone at 9.15am, he gained the impression that she would notify his relatives. The prison did not then contact any other family members until Monday 2 May. This is something that the man’s relatives said they were not happy about when they responded to the findings in the draft report. They thought that the prison should have been more proactive in contacting them directly and they should have been informed sooner.

78. Whilst at hospital, the man told the escort officers that he didn’t want anybody other than his fiancée to be informed of his condition. They telephoned his fiancée, who could not come to the hospital but wanted to be kept informed. She confirmed that she had not been in touch with his siblings.

79. At about 10.30am on 1 May, the man underwent an angiogram (a scan to find out more about his heart) and had stents (devices used to unblock arteries) inserted. One artery was completely blocked, another partially blocked. His blood pressure remained low and his prognosis was thought to be poor. His stents failed and he underwent further surgery that evening.

80. At 8.00am on 2 May, staff obtained the telephone numbers for the man’s sister and brother from a telephone book in his cell and his PIN telephone records and contacted them. His brother and sister-in-law visited him that afternoon and his sister and brother-in-law came to see him that evening. The next day, 3 May, his former wife and son visited him. His brother and sister-in-law visited on 4 May.

81. The man underwent heart bypass surgery on 5 May. Afterwards he was placed in an induced coma and one prison officer stayed with him in the

hospital. His son visited him in the intensive care unit on 6 May. His sister and brother-in-law visited him on 7 May.

82. An officer took over as the escort officer at 6.00am on 8 May. At 7.00am, nursing staff told her that the man's condition was rapidly deteriorating and his family had been called to the hospital. He died at 8.45am. His family arrived twenty minutes later. Later that morning he was remembered at the Sunday service at the prison.

83. A SO was appointed as the prison's family liaison officer. He consulted the man's siblings and agreed that the prison would treat the man's brother as his main next of kin.

84. A post mortem report determined that the man died of multiple organ failure following a heart attack. The post mortem also showed evidence of scarring in the heart tissue, indicating that he may have experienced mild heart attacks in the past which had gone unnoticed.

85. The man's sister, former wife and son visited Gloucester to see his cell. His funeral was held on 9 June. The family liaison officer and an officer attended.

ISSUES

Clinical care

86. The clinical reviewer has reviewed the clinical care that the man received in custody. Several years before his arrival in Gloucester, he was diagnosed with angina and treated with aspirin and atenolol. The clinical reviewer comments that this was ‘standard treatment at that time’.

87. An ECG taken in 2009 gave a normal result, which the clinical reviewer thinks casts some doubt on the diagnosis of angina. The man had never actually undergone any investigative procedures to confirm the diagnosis. Furthermore, repeated checks on his blood pressure across the years gave normal results. (High blood pressure would be a strong indicator of heart disease.)

88. The man’s family asked why he never underwent further tests if he had a diagnosis of angina. The clinical reviewer explains:

> ‘This was a clinical diagnosis [a diagnosis based on his symptoms] made in 2003 not supported by investigation. Later exercise ECGs [an ECG conducted during a period of exercise] indicate that if he was suffering from ischaemic heart disease it was likely to be mild. Further investigations (such as coronary angiography) carry risk in themselves, and would normally be arranged only if the exercise ECG was abnormal (which it wasn’t) or if the patient had symptoms of angina (which he didn’t).’

89. When the man arrived in Gloucester in October 2010, staff recorded that he had a history of damage to his heart. However, the clinical reviewer finds that there is no evidence in the previous clinical record entries to support this supposition. He comments that there are no documented episodes of chest pain in the months after the man arrived at Gloucester.

90. The clinical reviewer writes that the man’s medication was reviewed when he arrived at Gloucester, as is usual when a new prisoner transfers in. His longstanding prescriptions for atenolol and aspirin were continued. The clinical reviewer finds that this was ‘normal practice’ because:

> ‘These medications are known to be “cardio-protective” (i.e. lower the risk of cardiac events in patients diagnosed with angina).
>
> ‘There is no record that the man had suffered any adverse effects from the drugs (though it is possible — with the benefit of hindsight —that his indigestion might have been caused or aggravated by the aspirin. He told medical staff at a later date that he had had indigestion for “maybe a couple of years” but does not appear to have mentioned it on admission).’

28 April

91. The man's family told the investigator that they were under the impression that he first experienced discomfort on 27 April. The clinical record shows that he initially spoke to a nurse on the morning of 28 April, who referred him to Prison Doctor A. There is no evidence in clinical record to indicate that healthcare staff were alerted to his symptoms on 27 April. However, we obviously cannot discount the possibility that he started to experience symptoms the evening before he reported them to the nurse.

92. The clinical reviewer is satisfied that the staff who treated the man on 28, 29 and 30 April responded promptly and appropriately to his symptoms. When he was initially assessed by the doctor on 28 April, the ECG performed by the nurse gave a normal result and showed no evidence of a heart attack.

93. During interview, the doctor told the investigator that he would not necessarily have asked for an ECG if the man had been one of his patients in his community surgery, because he had classic symptoms of acid reflux. (These types of symptoms have been described on page 10 for ease of reference.) He said that the nurse who performed the first ECG had been especially diligent and cautious, delivering care beyond that which is expected. On this occasion, he thought that the man actually received better care in prison than was likely in the community.

94. The doctor said that the man could not have been admitted to hospital on 28 April because staff in the accident and emergency department would have looked at the ECG and rightly concluded that he was not having a heart attack. He explained during interview that there was no evidence in the clinical record that he ever suffered from exertional chest pain or required a GTN spray to relieve any discomfort whilst he was at Gloucester.

95. The clinical reviewer judges that the man was appropriately examined by the doctor on 28 April and that no evidence of heart disease was found. He considers the doctor's diagnosis of gastro-oesophageal reflux disease (GORD, or acid reflux) to have been appropriate and 'reasonable'. He writes that this is a common disease in older men. The man had complained of indigestion for some time and his pulse, blood pressure and ECG were all normal and gave none of the usual indications of heart disease. The clinical reviewer finds that omeprazole was the appropriate treatment for symptoms of GORD. The doctor commented during interview that the man had two common diseases (ischaemic heart disease and acid reflux) and that there was only evidence of the latter when he assessed him.

29 April

96. Nurse C assessed the man on the evening of 29 April. She consulted his medical notes before she went to his cell. He presented with the same symptoms as the previous day and when she took readings, these were similar to those the doctor had taken the day before. The nurse made the

same diagnosis of acid reflux and made sure that he took his dose of omeprazole. She ensured that he was referred to the doctor the next morning. She told him to press his cell bell again if he felt worse. He was sitting in his chair and remained there throughout the night. An officer continued to check him several times.

97. As indicated on page 10, symptoms of acid reflux can include shortness of breath and increased discomfort when lying down. The man had mentioned a feeling of breathlessness and sat upright in his chair for the rest of the night.

30 April

98. The man's family visited the prison after he died and spoke to a prisoner in a neighbouring cell. They understood from him that he might have found him 'collapsed' in his cell on the Saturday morning. They also thought that the staff provided him with a more comfortable chair because he was in pain. His relatives were concerned that he was not taken to hospital more quickly in view of his apparent collapse and level of pain.

99. The investigator interviewed the prisoner. He confirmed that he had never heard the man complain about chest pains prior to 28 April. He remembered that he was always lively and never complained about his health. Before he went to hospital, he said that he mentioned having trouble sleeping because of heartburn. He said that he experienced symptoms of acid reflux and indigestion when he lay down.

100. The prisoner told the investigator that he was unlocked from his cell as normal at about 8.10am on Saturday 30 April. He looked into the man's cell and spoke to him at about 9.00am before he went to work. His door was ajar and he looked pale. He was still sitting on his chair and did not find it easy to make conversation. He was bent over with his elbows on his knees. He had been given a more comfortable chair from the association room. The prisoner went to work and did not see him again before his admission to hospital at lunchtime. He presumed that he had a stomach bug.

101. There is no evidence that the man was so ill that he collapsed before he was admitted to hospital. Neither the officer, the nurse nor the prisoner witnessed such an incident.

102. Prison Doctor B asked for a second ECG during the morning, which showed an abnormal and concerning heart rhythm. He therefore contacted the hospital for advice and arranged to have him admitted. After the man reached the hospital, he had a huge and very damaging heart attack during the night.

103. The man's family have asked why he was not admitted to hospital more urgently on the morning of 30 April. The clinical reviewer comments in his clinical review:

> 'Following advice, the man was admitted that morning by urgent ambulance to hospital. Transfer by "urgent" ambulance (i.e. transfer

within two hours) rather than "emergency" ambulance (within the hour) would be specified by the doctor, depending on the condition of the patient. Emergency transfers are usually reserved for critically ill patients, and the records indicate that at his assessment that morning, He was mobile and his observations normal. Following his transfer it is clear that his condition deteriorated rapidly, and he was transferred to the regional cardiac unit in Bristol later that day.'

[In their responses to the draft report, the man's relatives disagreed that his observations had been normal during his last examination in the prison.]

104. The clinical reviewer judges that both prison doctors took a full medical history from the man and performed appropriate investigations (two separate ECGs). As part of his clinical review, he asked a cardiologist to review the first ECG taken on 28 April. They confirmed that the ECG showed no evidence of abnormalities and that therefore there would have been no reason to send him to hospital that day. Once Prison Doctor B asked for a second ECG on 30 April, and this indicated abnormal results, the clinical reviewer writes that the man's admission to hospital was 'correct and appropriate'.

105. The man's family asked the investigator if his transfer to hospital was delayed whilst the duty governor arranged for two officers to escort him to hospital. They explained to the investigator that they had been given to understand this by one of the governors they spoke to when they subsequently visited the prison.

106. The investigator spoke to the duty governor on the day. He said that he could not remember a delay taking place. He explained that the hospital is nearby and that even non-urgent ambulances do not take long to reach the prison. As already discussed, Prison Doctor B arranged for an urgent ambulance to take the man to hospital within *two* hours. Given that the ambulance was called at 11.55pm and left the prison with him at 1.15pm, I am satisfied that there was not a significant delay caused by the actions of discipline staff. He arrived at hospital within the timescale advised by clinical staff.

107. The clinical reviewer concludes:

'In my opinion there is no evidence that the man suffered from lack of care. Certainly, from the records it appears that he was thoroughly and properly assessed within a reasonable time, and admitted appropriately to hospital following deterioration.

'In my view his care in prison was as would be expected by a patient in the community.'

108. We acknowledge the concerns of the man's relatives. When they met the investigator, they expressed their belief that he would have been able to call an ambulance sooner himself if he had felt similarly unwell in the community. However, we are satisfied that he was moved to hospital once his condition

deteriorated. It is important to remember what the clinical reviewer means. Essentially, he thinks that the same decisions would have been made about the man's treatment if he had presented with the same symptoms to healthcare staff in the community. Although the context of imprisonment inevitably affects the patient's ability to refer himself to hospital, the clinical reviewer thinks that Prison Doctor B took the appropriate and necessary steps once he became concerned about him.

109. The forensic pathologist who completed the man's post mortem, also made the following comments about the care he received between 28 and 30 April in Gloucester:

> 'The main concern raised in this case is whether the man received appropriate healthcare prior to his admission to hospital. It would appear that his symptoms started on 28 April. I understand that the initial complaint of discomfort was believed to have been indigestion and was described as such by him. Indigestion is one of the main differential diagnoses of cardiac pain and so, in my opinion, it would have been reasonable for healthcare staff to have tried an indigestion remedy.
>
> 'A GP review was sought and undertaken and the symptoms and signs supported the diagnosis of indigestion. There were no further complaints from him until the evening of 29 April. Whilst it is suggested that he may have collapsed on this evening, the staff may not have been made aware as it was not documented as such in the records. Had they been aware, they may have acted differently. He was complaining of possible heartburn and breathlessness but he reportedly appeared clinically well and so further indigestion treatment was given and a GP review was arranged in the morning.
>
> 'At the time of this review [on 30 April], he was clinically unwell with ECG changes indicating an evolving myocardial infarction [heart attack]. It is likely that the initial complaints of indigestion over the preceding days were, in fact, ischaemic symptoms but the diagnosis was hampered by the description provided which was strongly suggestive of indigestion.
>
> 'It is not possible to say exactly when the critical ischaemic event occurred but the ECGs would seem to support an event sometime between lunchtime on 28 and the evening of 30 [April]. Early intervention in ischaemic cardiac events can improve the outcome but it is not possible to say whether an earlier diagnosis would have altered the outcome. He appeared to have received a reasonable level of healthcare input over the 48 hours prior to his admission. When it became apparent that he was clinically unwell, he was referred appropriately to the accident and emergency department.'

Medication

110. In February 2009, at Shepton Mallet, the man started a prescription for simvastatin (a preventative drug used to treat the onset of raised cholesterol) alongside atenolol and aspirin. He left Shepton Mallet and moved to Leyhill in January 2010. Two months later, a doctor doubled his dose of simvastatin. However, Leyhill then introduced SystmOne, a different type of electronic clinical record system, during the early summer. After the switchover to the new system, there is no indication that his prescription for simvastatin continued.

111. The investigator contacted the healthcare manager at Leyhill regarding the man's prescription for simvastatin. She replied:

> '…there does appear to be an unexplained gap in the records relating to the prescribing of simvastatin. The doctor is no longer working here so I can't clarify this with him. I can find no explanation why this happened, neither can I understand why the man would not have raised the issue with healthcare.'

112. We make the following recommendation:

The Head of Healthcare at Leyhill should explore whether the disruption in the man's prescription reflects a wider problem following the introduction of SystmOne.

113. Although the healthcare staff at Gloucester continued to prescribe atenolol and aspirin to treat the man's heart disease after he arrived in October 2010, repeat prescriptions were only clearly recorded on handwritten drug charts. It appears that the medication template on the electronic clinical record was only amended once by staff on 6 October, when he arrived. They recorded initial prescriptions for the two drugs. In contrast, the clinical record from Shepton Mallet between 2007 and early 2010 very clearly documents each and every repeat prescription. It does not appear that staff at Gloucester made best use of the electronic system. We make the following recommendation:

The Head of Healthcare at Gloucester should ensure that staff know how to clearly record repeat prescriptions on the electronic patient record system.

Family liaison

114. The man's siblings told the investigator that they were unhappy about the way in which they discovered that he was in hospital. One of the governors telephoned the man's brother on Monday 2 May, two days after he was admitted to hospital.

115. Although his siblings were upset, it is apparent that the duty governor made considerable efforts to locate the nominated next of kin in the early hours of 1

May. He eventually contacted the man's fiancée, partly because other telephone numbers and addresses were no longer current. Additionally, the man had made his wishes known when he was taken to hospital. Nurse C made the following entry in the clinical record on the evening of 1 May:

> 'Information received from the bed watch officers with the man that only his fiancée is to be informed and updated of his condition.'

116. The man's family asked the investigator why his next of kin details had not been updated. The Governor told my investigator that there seemed to have been an oversight when the man arrived at Gloucester. His details were not changed and had been out of date for some time. The Governor said that the staff had learnt a lesson from the confusion surrounding the man's next of kin. He explained that a policy has now been implemented. Notices will be put up on the wings once a year encouraging prisoners to provide staff with up-to-date contact details for their nominated next of kin. We are satisfied that the Governor has already taken steps to address this issue.

CONCLUSION

117. The man spent three decades in custody. As he aged in prison, he developed symptoms of angina and was prescribed appropriate medication. He seems to have become a well-liked prisoner at Gloucester. He never seemed to complain of chest pains after he arrived in October 2010. His health deteriorated very rapidly at the end of April 2011 and he never recovered from the major heart attack he suffered after he arrived at hospital.

118. We understand why the man's relatives were concerned when they heard that he had been complaining of feeling unwell for two days before he was admitted to hospital on 30 April. However, the clinical reviewer has found that he received a standard of care comparable with that he would have received in the community. We are satisfied that the doctors and nurses at Gloucester performed appropriate tests and admitted him to hospital as soon as they obtained an abnormal ECG result.

The response from the man's family to the draft report

119. The man's family were provided with a copy of the draft report of the investigation. We are grateful to them for taking the time to respond to the findings.

120. In their feedback, the relatives expressed their upset that he was not admitted more quickly to hospital on 30 April. His sister was frustrated that Prison Doctor B had continued reviewing his other patients at his morning surgery before arranging for her brother to go to hospital.

121. The man's son, brother and sister all thought that a '999' emergency ambulance should have been called and would have been if he had been living in the community at the time. They also both stated that they were told (when they visited the prison after he died) that the ambulance's departure had been delayed whilst the duty governor located two escort officers.

122. The family do not agree with the clinical reviewer's clinical review and do not think that the care that he received was comparable to that which he could have expected to receive in the community. They do not think that the man was diagnosed correctly and are also dissatisfied with the response to his deteriorating health on 30 April.

123. When they responded to the draft report, the relatives asked why he had not undergone further tests and checks to confirm his diagnosis of angina. They were also concerned that the man continued to be prescribed medication without any further diagnosis of his condition. As the clinical reviewer comments, further tests can carry their own risks and would only be prompted by new evidence, such as a concerning ECG. The man's son thought that his father's diagnosis of angina should have been rechecked regularly.

124. The man's son asked the investigator about paragraph 33 and why his father's health was not more regularly reviewed. We should stress that our report is necessarily proportionate. It does not attempt to summarise every medical assessment in the years before he arrived at Gloucester, but instead tries to highlight only the main developments in his clinical care. We apologise for any confusion in this respect.

125. With reference to paragraphs 35 and 109, the man's son and sister both expressed their disappointment that a problem with the electronic clinical record meant that his father's prescription for simvastatin was discontinued at one stage.

126. The man's son and sister both asked about a certain paragraph. We have amended the wording slightly to reflect two separate pieces of information. Firstly, that the man did not have a severe and enduring diagnosable mental illness such as schizophrenia. Secondly, he was prescribed antidepressant medication for mild depression.

127. The man’s son expressed his hope that the recommendation requiring healthcare staff to clearly record repeat prescriptions has now been implemented.

128. The man’s sister disagreed with the findings of the clinical review. She thought that, given her brother’s medical history, the healthcare staff at Gloucester should have considered the possibility of heart disease when he first began to complain of feeling unwell at the end of April.

129. The man’s sister also thought that the prison staff should have contacted his next of kin or fiancée as soon as he was admitted to hospital, and not the following day after he had suffered a heart attack.

130. In her response, the man’s sister expressed her confusion about her brother’s GTN spray. We agree that it is unclear why he seemed to have this spray when he first moved to Gloucester and was subject to ACCT monitoring. His relatives also noticed a spray in his cell when they visited after he died. However, there is no evidence that he was prescribed GTN spray at Gloucester so the situation remains a little unclear, which we understand is frustrating for his family.

131. The man’s sister was confused about the statement given to the investigator by the prisoner. She had understood from him that he had found her brother collapsed behind his cell door. She told the family liaison officer that her brother had also given her this information when she saw him in the hospital.

132. The man’s sister said that she did not think that the governor had adequately conveyed the seriousness of her brother’s condition when she contacted the family on 2 May. The man’s brother expressed dissatisfaction that the investigator had not interviewed the governor. Unfortunately, the Ombudsman’s investigations are necessarily proportionate. In this instance, the investigator chose to focus on members of staff who treated the man and dealt with his care prior to his admission to hospital.

133. In her response to the draft report, the man’s sister questioned the decision to move her brother back to closed conditions because of the risk he presented in an open prison. She thought that the move had caused her brother to become stressed. An explanation of the reasons for the move is included. We would stress that the severity of the man’s original offence of murder clearly needs to be taken into account by staff making these kinds of decisions. It was evident to staff that he had lied to them and that therefore his risk level was uncertain.

RECOMMENDATIONS

Gloucester

1. The Head of Healthcare at Gloucester should ensure that staff know how to clearly record repeat prescriptions on the electronic patient record system.

   The Head of Healthcare at Gloucester accepted the recommendation and provided the following response:

   ‘All Nurse Prescribers are aware that repeat prescriptions need to be recorded as and when they are issued and following a clinical assessment by the prescriber. This has been fully discussed with the new Healthcare providers and has been to the local Drugs and Therapeutics Committee. The GPs are also aware of the need to do the above when doing repeat prescriptions. A memo will be sent to all Nurse Prescribers and GPs as a reminder.’

Leyhill

2. The Head of Healthcare at Leyhill should explore whether the disruption in the man’s prescription reflects a wider problem following the introduction of SystmOne.

   The Head of Healthcare at Leyhill accepted the recommendation and provided the following response:

   ‘A review was carried out and the disruption in the man’s prescription appears to have occurred during the time when the electronic patient records were migrating from one electronic patient record system to another. This was from Emis to SystmOne.

   ‘During migration the medication prescribed on Emis was transferred to SystmOne by a member of the Avon IM & T Consortium. On further investigation it appears the Simvastatin was not transferred. As a result of this the Simvastatin was not re-ordered.

   ‘I am confident this is a one off occurrence and is not a reflection of a wider problem.’