Investigation into the circumstances surrounding the death of a man at HMP & YOI Hull in May 2010

Report by the Prisons and Probation Ombudsman for England and Wales

January 2012

This is the report of an investigation into the death of a man, a prisoner at HMP Hull, who died in May 2010. The cause of death was acute cardiac failure, as a consequence of arrhythmogenic and ischaemic heart disease, he was 53 years old.

I offer my condolences to those affected by the man's death. I also apologise for the additional distress caused by the delay in issuing this report.

The investigation was undertaken by an investigator. A clinical review of the healthcare provided to the man during his time at HMP Hull was commissioned by the local PCT and I am grateful to the clinical reviewer for his review. I would also like to thank the Governor of HMP Hull and his staff for their co-operation throughout the course of the investigation.

The man was remanded into custody at HMP Hull on 2 March 2009. He informed the doctor during his reception health screen of his existing health conditions, which included angina. The following day, he reported chest pain and was examined by the prison doctor. He was admitted to hospital and underwent a coronary artery bypass, a surgical procedure used to divert blood around narrowed or clogged parts of the major arteries, to improve blood flow and oxygen supply to the heart. Healthcare staff at the prison monitored his angina closely. They encouraged him to take his medication and informed him of the consequences of not taking it. He was admitted to hospital on three other occasions for treatment for his heart condition.

On an evening in May, the man's cell mate called staff as he had found him unresponsive on the cell floor. Staff responded and attempted to resuscitate him until the arrival of ambulance staff. He was taken to hospital where further, unsuccessful, resuscitation attempts were made and he was pronounced dead a short while later.

I am satisfied that the man was given appropriate care at Hull and referred to hospital specialists promptly for treatment. Also, when he was found in his cell unresponsive, staff took the relevant steps to assist him. However, I make three recommendations to improve the response to medical emergencies and these have all been accepted.

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**

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SUMMARY

1. The man was born in November 1957 and died in May 2010 at hospital. He was 53 years old. He was remanded into HMP Hull on 2 March 2009, charged with serious offences for which he was subsequently convicted. On reception to the prison, he told staff that he had been diagnosed with angina. (Angina is a syndrome (a collection of symptoms caused by an underlying health condition) that is caused when the supply of oxygen-rich blood to the heart becomes restricted. One of the common symptoms is chest pain.)

2. The day after he went into prison, 3 March 2009, the man reported chest pain and was examined by the prison doctor. The doctor advised that he was to have an electrocardiogram (ECG), a test that measures the electrical activity of the heart). He then went to the Accident and Emergency department for further assessment. He stayed in hospital, where he was diagnosed with heart disease and underwent a coronary artery bypass on 23 March. (This is a surgical procedure to relieve angina and reduce the risk of death from coronary artery disease.) He returned to Hull on 13 April, where he had a brief stay in healthcare before being discharged back to a residential wing.

3. The man was admitted to hospital again on 14 May 2009, with difficulty breathing and unstable angina. He was discharged back to Hull on 3 June. He attended various hospital and healthcare appointments during the course of the year, to monitor his heart condition, back pain and his medication. It was noted that he did not cooperate with taking warfarin (a medication that helps prevent blood clotting.) He was also subject to suicide and self-harm monitoring under the Assessment, Care in Custody and Treatment (ACCT) procedures after receiving a lengthy sentence on 14 September.

4. On 21 January 2010, the man went into hospital for a radiofrequency ablation (treatment that uses electrical energy to destroy tissues in the heart that are causing rhythm disturbances) and stayed overnight. He then attended the healthcare department regularly over the following months, but still refused to take his warfarin. He was again admitted to hospital on 24 April with a racing heart and difficulty breathing. He was diagnosed with atrial flutter (rapid, irregular heart rate) and tachycardia (abnormal heartbeat) and discharged back to Hull on 29 April.

5. The man was seen by a nurse for an ECG on 10 May. During his appointment, he mentioned to her that he felt depressed and was having thoughts of harming himself. The nurse began the suicide and self-harm prevention procedures and referred him to see the doctor and mental health team. He subsequently saw a doctor, who prescribed an antidepressant. At a meeting with the mental health team on 20 May, he said that although he was feeling low, he no longer had thoughts of self-harm. He said he felt supported by wing staff and peers and was attending education and art classes. The ACCT document was then closed.

6. In May the man's cell mate called staff using the emergency bell in the cell. Discipline and medical staff responded. The nurses assessed the man and attempted to resuscitate him while the officers obtained emergency equipment

7. Prison Managers contacted the man's family shortly afterwards and offered their assistance. A prison family liaison officer was appointed. A debrief was held and both staff and the man's cell mate were offered support. The Governor and prison family liaison officer attended the funeral on 7 June.

8. The pathologist found that the cause of death was acute cardiac failure, as a consequence of arrhythmogenic and ischaemic heart disease. This is a condition in which fatty deposits build up in the linings of the walls of the coronary arteries and causes a narrow artery and reduced blood flow to the heart muscle. The inquest concluded that the man died from natural causes.

9. The investigation has found that the man was given appropriate care by prison staff in respect of his medical conditions. However, I make three recommendations for improvements in aspects of the response to medical emergencies.

THE INVESTIGATION PROCESS

10. The investigation was opened at Hull on 9 June 2010, by an investigator, who met the Governor and representatives of the Independent Monitoring Board (IMB) and Prison Officers' Association. The prison provided copies of all the documentation relating to the man. Notices of the investigation were issued to staff and prisoners, inviting those who wished to provide information regarding his death to make themselves known to the investigator. No one came forward.

11. The investigator wrote to the local Primary Care Trust (PCT) to commission a review of the clinical care given to the man at Hull. The PCT appointed a clinical reviewer to conduct the review. He received copies of relevant medical documentation, upon which he based his findings. He also conducted interviews with relevant staff, jointly with the investigator.

12. The investigator also contacted HM Coroner for the East Riding and Kingston upon Hull District to inform him of the nature of the investigation. She subsequently gave him information gained from the investigation to assist the inquest, which was held at the beginning of April 2011. The verdict was that the man died from natural causes.

13. One of my family liaison officers wrote to the man's family at the beginning of the investigation. She informed them of the investigation and offered them the opportunity to raise any questions or concerns they would like to be addressed. The family raised no issues of concern at that time, they will however have an opportunity to receive and comment on the report if they should chose to do so.

14. HMP Hull is a category B local prison holding remand and sentenced adult male prisoners and young offenders. Prisoners are risk assessed when they come into prison and given a category based on their offence and the risk that they pose to the public should they escape. There are four categories: A, B, C and D, with category A prisoners being the most dangerous. Category B are prisoners for whom the highest security conditions are not necessary but for whom escape must be made very difficult.

15. Since 2002, Hull has undergone a period of expansion and now holds over 1000 prisoners. The expansion included a purpose built healthcare centre offering 24 hour healthcare and a multi-bedded inpatient ward and cellular accommodation. In 2009, a terminal care suite was adapted. Medical services are contracted out to Hull Teaching Primary Care Trust.

16. The prison accepts prisoners sentenced to Imprisonment for public protection (IPP) as well as those given the conventional mandatory life sentence. (IPP prisoners have no automatic right to release at the end of their sentence). Hull runs a number of offence-related courses and prisoners are often re-categorised to lower security categories once they have completed them.

17. Each prison has an Independent Monitoring Board. The IMB is appointed to each prison by the Secretary of State for Justice. They are not members of the Prison Service, nor are they part of the management team. They are required to produce an annual report on the prison to the Secretary of State, highlighting good practice and flagging up areas of concern. The IMB report for 2008 highlighted the problem of moving prisoners around an overcrowded prison system. In common with other category B prisons, Hull also contains a number of category C and even category D prisoners who are waiting for spaces at lower category prisons.

18. In late 2008, Hull scored positively in the Measuring Quality of Prisoner's Life (MQPL) survey and attained 'Best in class for Diversity'. It was rated as a "safe and decent prison". The National Offender Management Service (NOMS) is responsible for the management of prisons in England and Wales. Every three months it publishes an assessment of each prison's performance against 34 measures. Prisons can gain a rating of between one (serious concerns) and four (exceptional performance). At the time of the man's death, the NOMS rating was level four – awarded to "excellent establishments that are delivering exceptionally high performance".

19. Her Majesty's Inspectorate of Prisons last inspected Hull in an announced inspection in November 2008. The inspection report, published in March 2009, complimented Hull on staff prisoner relations, activities, diversity, resettlement and time out of cell. The healthcare offered was judged to have "improved considerably" since the previous inspection.

Previous deaths at Hull

20. Since the Ombudsman was given responsibility for investigating all deaths in custody for England and Wales in April 2004, there have been seventeen deaths at Hull, eleven of which were due to natural causes. The last death was in April 2009. There are no similarities in relation to this investigation and any of the previous deaths at Hull.

KEY EVENTS

21. The man was remanded into custody at HMP Hull on 2 March 2009, charged with serious offences. He had previously committed a number of minor offences and had been in prison 30 years before. New prisoners go through the reception process, including risk and health assessments. During his first reception healthscreen, he told the prison doctor that he was a smoker, suffered back pain from an old laminectomy (a spine operation to remove a portion of the vertebral bone), had angina for which he used glyceryl trinitrate (GTN) spray (medication that helps to make veins and arteries relax and widen) and suffered from depression.

22. The following day, 3 March, Prison Doctor A examined the man as he had chest pain. The doctor recorded in the medical notes that his chest was clear, but he had an irregular pulse. He took one dose of his GTN spray, however this did not relieve his symptoms and so the doctor decided to perform an electrocardiogram (ECG) (a test that measures the electrical activity of the heart) in the healthcare centre. After the ECG, the doctor sent him to hospital for further assessment.

23. The man was admitted to hospital, where he was diagnosed with cardiac changes – infarction (an area of tissue that dies due to a local lack of oxygen caused by obstruction of the tissue's blood supply) and atrial fibrillation (abnormal heart rhythm) for which he was prescribed warfarin, a medication that thins the blood to prevent and treat the formation of harmful blood clots. He stayed in hospital and underwent a coronary artery bypass on 23 March.

24. The man was discharged back to Hull on 13 April. He was initially admitted to healthcare before being transferred back onto a residential wing on 17 April. Staff put in place a care plan to ensure appropriate care and assessment of him during his recovery from surgery and to monitor his angina. The clinical reviewer commented that this was “good practice in potential vulnerable patient”.

25. Staff made regular, daily observations of the man and recorded them in his medical record. Healthcare staff began weekly monitoring of his international normalised ratio (INR) – (a procedure used to monitor the level of anticoagulant in the blood) to establish the correct dosage of warfarin to be prescribed.

26. On 23 April, the man attended an appointment with a dietician, who recorded that his body mass index (ratio of height to weight) was 20, which is thin. He was prescribed Fortisip liquid (a supplement drink) to help build up the weight that he had lost and also to help promote wound healing from his recent surgery. It was noted that once he had increased his weight, the supplements were to be stopped. A smoking cessation referral was made for him, although there is no evidence of this being arranged, or him attending this appointment. He was to be reviewed by a doctor on 6 May.

27. Nurse A assessed the man on 27 April. He was suffering from shortness of breath, a racing heart as well as pins and needles in his right arm. She found his blood pressure to be low and spoke to Prison Doctor B regarding his symptoms. The doctor also examined him and diagnosed paroxysmal atrial fibrillation

(irregular heart rhythm). He advised that his medication did not need to be increased, however if his symptoms became more disabling he would need a cardiology assessment.

28. It is noted in the man's medical record on 1 May that he was seen by a cardiologist (a doctor who specialises in treating diseases of the heart and blood vessels). The cardiologist reviewed his medication and asked for him to be reviewed again in six weeks time.

29. The man appeared at Crown Court on 6 May, in relation to the offences for which he had been remanded. His trial was scheduled for 7 September. The following day, Nurse A assessed his weight and noted that there had been no further weight loss since April and that his weight was to be monitored at every INR appointment.

30. A week later, on 14 May, Nurse A examined the man as he was suffering from breathlessness on exertion. He had previously complained of breathlessness at night with palpitations and had seen a doctor, who advised that if it worsened he was to be reviewed by a cardiologist (heart specialist). She discussed his symptoms with Prison Doctor C and it was decided to send him to hospital for further assessment. He underwent further tests and a 24 hour tape of his heart showed no signs of abnormal electrical activity. He was discharged back to Hull on 28 May, with a follow up review scheduled for six weeks later. He was given amiodarone (medication used to treat irregular heart beat) for a trial period, however this affected his ECG results and so it was discontinued.

31. The man attended an appointment with a doctor at the hospital on 10 June. Arrangements were made for him to have a radiofrequency ablation (treatment that uses electrical energy to destroy tissues in the heart that are causing rhythm disturbances) and he was also referred to a remedial gym. Healthcare staff were informed of this on his return to Hull.

32. On 20 July, the man went to see Nurse B as he was experiencing anginal attacks much more frequently. He had felt unwell over the weekend, was breathless on exertion, and was experiencing dizziness, numbness and tingling down his left arm. He said that his GTN spray was not always effective and that he was taking his medication as prescribed. She referred him to Prison Doctor D, who noted that he looked very pale, his pulse was racing and dropped very low. The doctor promptly sent him to hospital for further assessment, where he was diagnosed with muscular pain and no further cardiac changes. He was discharged back to Hull.

33. A doctor examined the man on 14 August as his chronic back pain had become worse and he was concerned about his circulation as his legs felt 'dead' whilst lying in bed. The doctor noted that he had good reflexes, his pulse was normal and he was able to put his shoes on and off. He advised him to have five days bed rest and take two 500mg paracetamol tablets four times a day to help manage the pain.

34. Healthcare staff continued to monitor the man's INR level on a weekly basis, giving his results to the anti-coagulation team to enable them to prescribe the correct dosage of warfarin. On 20 August, it was noted in his medical record that he had not taken his warfarin for eight days, stating that he was unable to climb the stairs to the medication hatch due to back pain and vertigo (condition where the environment around you seems like it is moving or spinning). Healthcare and discipline staff were persistent in encouraging him to take his warfarin and informed him of the health risks involved if he did not. The clinical reviewer recorded this as "evidence of good team work" within his clinical review.

35. The man's medical records show that Nurse C received a phone call from an employee from the Crown Prosecution Service (CPS) on 3 September regarding his upcoming trial. The employee informed her that he had told the CPS that he was suffering from short term memory loss. The nurse noted that he had also reported this to healthcare staff on a daily basis. The employee asked for him to have an urgent assessment for fitness to stand trial. The nurse checked his medical history and found that there were no reported mental health issues and no reference to memory defects. She spoke with the Head of Custodial Sentences, who agreed to contact the employee directly.

36. Nurse D assessed the man the next morning, prior to leaving for court. He made no reference to memory loss, but said that he was unable to attend the medication hatch on his wing to collect his warfarin. She pointed out that he had just climbed as many stairs to come to reception and did not appear to have any symptoms of anxiety. It was noted that he did not reply and went to court.

37. The man's trial started on 7 September. He attended court daily and was sentenced to 19 years and six months imprisonment on 14 September. Nurse E spoke to him on his return to Hull. He said that he felt terrible and was dumbfounded by his sentence, as he was not expecting it. He was also worried about his wife's welfare as she had been diagnosed with cancer. He became tearful and said that he was unsure whether he would "do something" and that he needed time to adjust. She opened an ACCT document and admitted him as an inpatient in the healthcare centre for further assessment and to see the mental health team.

38. The man was observed hourly throughout the day and night. He expressed that he had no suicidal intent, but said that he could not guarantee his safety. He remained low in mood and he was to remain subject to monitoring under the ACCT procedures until he came to terms with his sentence. Prison Doctor A reviewed him on 15 September and discussed his life circumstances. The doctor advised him to think of positive things that had happened to him recently, for example his heart operation and explained things would become easier once he accepted his sentence.

39. Staff continued to regularly observe the man and by 18 September he was engaging in activities on the healthcare wing and was eating and drinking well. He still hadn't come to terms with his sentence and needed regular support. He went back to his wing on 21 September, but staff continued to monitor him whilst he settled back in.

40. A mental health worker held an ACCT review with the man on 24 September. He spoke about negative experiences over the previous few years. He said this had contributed to his anxiety and depression for which he had been prescribed medication in the past. He added that he did not leave his cell much and did not attend education or work. He explained that he was suffering from nightmares and flashbacks, which was affecting his sleep. He told her that his wife visited and wrote to him regularly. She noted in his medical record that he had suicidal thoughts, but would not act on them due to the impact it would have had on his family. She closed the ACCT however he was to receive further mental health reviews.

41. The man attended appointments with the mental health worker on 7 and 16 October where they discussed coping strategies and self-help information. He kept occupied by reading, so she set him a goal to start attending the library.

42. As the man was still not cooperating in taking his warfarin and adamant that he could not use the stairs, healthcare staff admitted him to the healthcare centre on 20 October to review his health and well being. They looked at strategies to help him have better access to his medication. This included arranging for one of the nurses to deliver his warfarin to him and also moved him up a level on the wing so that he had only one flight of stairs to climb to the medication hatch. He was also reminded that he could use the lift. He was discharged back to the wing three days later.

43. It was noted in the man's medical record that he was able to use the stairs to attend visits and collect his meals. This was discussed with him and he began to attend the treatment hatch again to collect his medication, however he still did not do so on a regular basis and missed several doses over the next few months.

44. On 13 November, the man had a mental health review with the mental health worker. They discussed recent events and his progress. He told her that the move to the second floor had helped to overcome his feelings of anxiety. Although he did still feel anxious at times, he was able to collect his medication. He said he was gradually pushing himself to do more and he had had a visit from his wife who was feeling better, which helped to relieve some of his concerns. A follow-up appointment was made and she discussed discharging him from the mental health service.

45. The man's next mental health review was held with the mental health worker on 27 November. She recorded that he was managing well and was continuing to collect his medication from the third floor, although he was anxious whilst getting it. He had been attending the library and was engaging with others on the wing. This had helped him to feel less anxious, so she discharged him from the service as she considered that no other action was needed at this time. She advised him to ask if he felt that he needed the service in the future.

46. The hospital telephoned the prison on 3 December to advise that the man was booked to have his radiofrequency ablation treatment on 21 January 2010, with one overnight stay. He was also required to attend the hospital on 18, 19 and 30

47. The man had a meeting with the Offender Manager and Offender Supervisor on 15 December. It was recorded in his sentence plan document that they explained the meetings occur every twelve months. He told them that he was finding it hard to cope with his time in custody whilst his wife was terminally ill and that he had suffered with depression in the past. The support available to him was discussed as well as the possibility of him completing a sex offender treatment programme (SOTP). He stated that he could not see the benefits of completing the programme.

48. Healthcare nursed gave the man the Fragmin injections and he was admitted to hospital on 21 January 2010 to undergo the radiofrequency ablation procedure. He stayed at hospital overnight and was discharged the next day.

49. The man started experiencing chest pain and palpitations at night and went to see Prison Doctor A on 2 February. The doctor admitted him to healthcare and advised an ECG to be done whilst he was experiencing the chest pain. His pulse was regular, he had good colour and was moving around well with no shortness of breath. He experienced pain during the night, however he said his GTN spray quickly eased this. The doctor advised that he was to remain in healthcare for a second night and continue to be observed. He had no further chest pain and stated that he felt good from reducing his smoking. He returned to the wing on 4 February.

50. As the man was still experiencing chest pain during the night, he attended a cardiology appointment at hospital on 22 April. He was prescribed sotalol (to treat rhythm disturbances in the heart) as he had relapsed back into an abnormal heartbeat after the radiofrequency ablation and an ECG was scheduled for the end of May.

51. On 24 April, the man went to the healthcare centre. He was experiencing a racing heart and difficulty breathing. His medical notes show that the out of hours doctor was contacted and staff were advised to send him to hospital, given his observations and his past medical history. He was admitted to a cardiology ward at hospital and further ECGs were taken. Healthcare staff issued the ward with his INR results form the last six months. He was diagnosed as having atrial flutter and tachycardia, (an irregular and fast heartbeat). He was discharged on 29 April.

52. Nurse F performed an ECG on the man on 10 May. He told her that he was feeling very low and had thought about harming himself. He said that he felt physically unwell and that eighteen months ago he was fit and well, apart from his back pain. He felt that everything had gone wrong at once. She opened an ACCT document to begin monitoring him under the suicide prevention and management of self-harm procedures and discussed her concerns with an officer on his wing.

53. The man attended an appointment with Prison Doctor E on 17 May, where he discussed his mood and current feelings. He told the doctor that he would like to start Prozac (an antidepressant) again, and that it had been prescribed in the past. The doctor explained the cardiac side effects of Prozac. However, he agreed to prescribe it, advising the man that if he felt chest pains or palpitations he was to see a doctor.

54. Nurse F, who had opened the ACCT procedures the previous week, reviewed the man on the morning of 20 May. He told her that he felt more supported by wing staff and his peers and was feeling much better. She then closed the ACCT monitoring. The mental health worker went to see him on the wing that afternoon and spoke to him about how he was feeling. He repeated that he was still feeling low regarding his wife's illness and not being able to support her. However, he was attending education and art class everyday and finding it very beneficial.

May 2010

55. The man was in his cell one evening in May. At 6.00pm, his cell mate pushed the cell bell. (Each cell is fitted with a bell to enable prisoners to request assistance.) The Senior Officer (SO) attended to the cell bell from the wing orderly office, along with Officer A, who attended from his office. The officer talked to the cell mate, through the door hatch, who said he could not get a response from the man. The officer saw him on the bottom bunk and due to his appearance called a code blue over the radio. (Most prisons use a code system to indicate a medical emergency. Blue indicates that a person has breathing/respiratory problems and red that the person is bleeding. The codes allow the medical staff to respond with appropriate equipment.) The officer said during his interview with the investigator and clinical reviewer:

> "When I got to the cell I opened the hatch and I think his cellmate was there saying he could get no response from the man… so I immediately got onto our radio system and called what's called a code blue. That alerts Oscar 1 who's in charge of the prison at that time and the nursing staff that we need urgent, urgent assistance really."

56. The officer opened the cell door approximately a minute later when Nurse G and Officer B arrived. The nurse went into the cell and conducted a rapid assessment. The man appeared unresponsive, bradycardic (slow heart rate), cyanosed (blue colouration of the skin due to lack of oxygen) and had a respiratory rate of four (amount of breaths taken in one minute). She immediately asked Officer A to get the emergency bag and Officer C to call a "blue light" ambulance and a second nurse to assist. The clinical reviewer said in his clinical review that it was "proper triage and a good set of commands by team leader – Nurse G."

57. Officer A ran to get the emergency bag from the wing orderly office then helped Officer B move the man to the floor of the cell to perform cardio pulmonary resuscitation (CPR). The nurse showed Officer B how to do chest compressions whilst she then provided oxygen to the man using an Ambu-bag (self-inflating resuscitator). CPR was performed at a rate of two breaths to thirty compressions.

"Although I'm not medically trained it was obvious that things had sort of stepped up a bit and I was thinking about the effects on the cell mate so I asked him if there was anyone he'd like to go and sit with and we arranged for that."

58. At approximately 6.09pm, another nurse went to the cell and took over from Nurse G, who left the cell to talk to the ambulance control and inform them of the man's critical condition. She then went back to the cell and assisted the nurse in performing CPR.

59. At 6.19pm the ambulance crew arrived. They noted that the man had no respiration or blood pressure and was unconscious. The ambulance crew took over the resuscitation attempt, using a defibrillator (machine used to give the heart an electric shock to restore rhythm) and giving intravenous drugs to help increase heart rate. Two officers made an escort bag and collated all relevant paperwork ready to escort him to hospital in the ambulance. He was taken by ambulance to hospital at approximately 6.56pm, with ambulance crew still attempting to resuscitate him. He was not handcuffed.

60. The ambulance arrived at approximately 7.10pm and the man was taken to the resuscitation ward, where medical staff attended to him. The escort officers were relieved by two more officers at approximately 7.50pm and stood back whilst medical staff continued to resuscitate him.

61. Despite extensive resuscitation efforts, the hospital doctor informed the officers of the man's death at 7.55pm. One officer then informed the prison by telephone and one of the senior officers there contacted the duty governor.

62. At approximately 8.05pm, resuscitation ward staff gave one officer the man's belongings, which consisted of a watch, comb, prison ID, his ring and clothes. The officer asked the doctor to supply a letter to confirm that he had died. He was moved from the resuscitation ward to a side room at 8.50pm, where both officers stayed in attendance outside. At 9.20pm, the duty governor and the Head of Custodial Services arrived at the hospital and all staff returned to HMP Hull.

63. The Governor informed the man's next of kin, his son, of his death at 9.20pm by telephone due to the distance to the home address. The Governor then spoke to the man's wife at 9.45pm and arranged for her to travel to Hull to view his body. During the morning, another Governor spoke to the man's wife, who asked him some questions about events leading to his death and what would happen next. Once he had the information she had asked for, he spoke to the man's son. He told him that his mother had been very upset during the call. He asked the Governor to give him the information, saying he would pass it to his mother.

64. A family liaison officer was appointed and kept regular verbal contact with the man's wife and son. She relayed relevant information regarding the

65. On 23 May, a member of the chaplaincy included prayers for the man in the morning worship service and stated that these were well received. He also spent time with the cell mate, who talked about the events of the previous night and was assured he had done all that he could.

66. A hot de-brief was held that morning by a Governor. (A hot debrief is a meeting for staff to discuss issues and any lessons learned following serious events such as deaths in custody, hostage situation or escape attempt. The meeting should focus on reassurance, information sharing and how staff can support each other.) All staff were offered support from the care team and reminded that they could also speak to their line managers or any other manager. Staff then each spoke of their part in the incident and were asked to make any suggestions or recommendations. All the staff involved thought that the response was excellent and that both discipline and healthcare staff had worked well together. When asked at interview if she had been supported after the incident, Nurse G stated “a lot yes, the support in the prison is great for anything like that”.

67. The man’s wife rang the prison in the evening as staff had not telephoned her as they said they would. The duty governor telephoned her and said that another governor had passed the information to her son. However, his son had not passed on the information. The governor then answered the questions and offered her condolences on behalf of the Governing Governor and the prison.

68. A governor sent a letter of condolence to the man’s wife, also informing her that all his property and monies would be returned to her. He advised that if she had any questions or, she was welcome to contact another governor or the family liaison officer.

69. The family liaison officer and a governor visited the man’s wife at her home on 26 May and returned his property and money. The family liaison officer offered her a visit to the prison after the funeral which took place on 7 June. They both attended and the prison provided a financial contribution to the cost of the funeral. The man’s wife and daughter sent letters of thanks and kind regards to all staff involved in the attempts to save his life and for all the help and support offered to them after his death.

ISSUES

Timely and appropriate clinical care

70. The clinical reviewer judges that the overall level of clinical care given to the man whilst he was at HMP Hull "was entirely appropriate and a good standard".

General

71. Throughout his time at Hull, the man attended regular appointments with healthcare staff and received treatment at an outside hospital for his angina. Both healthcare and discipline staff monitored his health and wellbeing on a regular basis, documenting all relevant information in his medical and wing records. Good communication and care planning is evident from his prison documents.

Warfarin

72. The man was prescribed warfarin for his angina. Staff monitored his INR weekly to be able to prescribe an appropriate dose. He refused to take his warfarin. He said that he suffered from anxiety and vertigo and that this, including his back pain, was preventing him from climbing the stairs to collect his medication from the treatment hatch. However, staff observed that he was able to climb the stairs to collect his meals, go to visits and also to go to reception.

73. Both healthcare and discipline staff discussed this with the man and arranged for him to be moved to a more accessible location on the wing and also for a nurse to bring his medication to him. Although he stated that he still suffered from anxiety, he began to collect his medication. Staff encouraged him to take his warfarin and reminded him of the risks involved in not taking it. Both healthcare and discipline staff showed evidence of good communication and team work in trying to ensure he cooperated with taking his medication.

Suicide prevention and self-harm management procedures at HMP Hull

74. In his first reception healthscreen, the man said that he had suffered from depression in the past and had previously been on antidepressants. He was first subject to monitoring under the ACCT suicide prevention procedures in September 2009, when he received a lengthy sentence. Staff monitored him appropriately and put in place a careplan for him. They offered him support and encouragement to help him come to terms with his sentence and the ACCT was closed soon after. He still received regular reviews from a member of the mental health team until late November.

75. The man spoke to Nurse F about his feelings during an ECG check-up in May 2010. He had begun to feel depressed and was having thoughts of self- harm. He said that he was innocent and everything had seemed to go wrong at once. The nurse promptly opened an ACCT plan, relayed her concerns to staff on his wing and referred him to see a doctor and the mental health team. He was prescribed Prozac. The ACCT document was closed ten days later.

76. The opening of the ACCT plans was clearly appropriate on both occasions, given the circumstances and mood presented by the man. The clinical reviewer considered that this was good practice.

Discovery and resuscitation attempt

77. Staff were alerted to the man being unresponsive when his cell mate pressed the cell bell. When Officer A arrived at the cell, he radioed for assistance indicating a "code blue". Nurse G and the Senior Officer responded quickly to the alert. The nurse took charge of the situation giving appropriate commands to others and making quick and relevant decisions, such as the need for a blue light ambulance and for another nurse to attend. Timely and appropriate resuscitation was given as the incident developed.

78. After the nurse examined the man, she asked an officer to fetch the emergency medical bags and for an ambulance to be called. The clinical reviewer raises two issues about these actions and makes recommendations, which I endorse, to speed up the process of emergency treatment.

First aid training

79. The clinical reviewer notes that the nurse did not collect the emergency equipment before going to the cell. Therefore, although she began CPR immediately, she did not have the full range of equipment available. However, the bags were in the wing office and the officer returned shortly. She then used an ambu bag to give the man oxygen while an officer carried out the chest compressions. She did not ask for a defibrillator and so it was not available.

80. During his investigation, the clinical reviewer spoke to the inpatient manager about what the emergency response nurses are expected to do. She said that the nurse should attend a code red/blue call with the emergency equipment and defibrillator.

The Head of Healthcare should remind all staff where the defibrillator is kept and that the emergency bags should be taken to all code blue alerts.

81. In some prisons, a code blue call automatically leads to control room staff requesting an emergency ambulance. This is not the case at Hull. The records show that the nurse asked for an ambulance four minutes after the man's cell mate pressed the cell bell. The control room called for an ambulance five minutes after later, at 6.09pm. The clinical reviewer discusses this,

> "I recognise that if the control room were to trigger off an alarm to the ambulance service for every code blue then there might be a number of false calls. The request can always be cancelled and the crew stood down. Rapid and prompt assessment of the situation by the first attender should be the aim to minimise any delays. The crucial time for restoration of a good heart rhythm and a successful outcome- life and minimal impairment is in the first few minutes."

He concludes, “I do not feel in this case the patient was put at risk as the ambulance in fact arrived promptly.” The Governor and Head of Healthcare may wish to discuss this with the local ambulance service.

82. The clinical reviewer notes that none of the officers were confident enough to carry out CPR. However, the nurse showed an officer how to do chest compressions and he carried on while she gave the man oxygen. The officer’s willingness is commendable. The clinical reviewer suggests that wing officers could be trained as “first responders”, allowing them to spot a heart attack or similar collapse and perform basic life support until trained help arrives. He notes that members of the public are trained in this role and that it is readily available in the city.

The Governor and Head of Healthcare should consider reviewing basic life support training and ensure that on every shift there are wing staff trained to carry out life support.

83. Whilst the nurse was carrying out CPR, the ambulance service controller asked to speak to her, calling her away from the man’s side. Fortunately, by that time, another nurse had arrived and she felt able to go to the office to inform the controller of the man’s condition. The clinical reviewer suggests that rather than a trained nurse leaving a patient, he or she should relay the facts via an officer. He suggests to healthcare managers that:

> “Consideration be given to a few direct commands being used to the Ambulance service which will allow them to give proper priority to the case. E.g. patient not breathing- nurses are performing cpr- request urgent paramedic support.”

The Head of Healthcare should consider training emergency response nurses to pass a summary of the patient’s condition to the ambulance service via an officer.

Support for staff

84. A hot de-brief took place the following morning. All staff involved in the incident were reminded that they could talk to the care team, or any manager should they wish to do so. All staff were given the opportunity to talk about their role within the incident and whether they thought anything could have been done better or if any recommendations needed to be made. Everyone involved stated that healthcare and discipline staff had worked well together and that they had done all that they could to try and save the man.

Family liaison

85. When the man’s wife telephoned the prison after she learned of her husband’s death, she was, understandably, very distressed. Nevertheless, she had questions about his death and practical details such as the post mortem. When the governor explained what had happened, she said that she appreciated that another governor had not wanted to add to her distress. However, it meant that

CONCLUSION

86. The man was reviewed regularly by various staff within the healthcare centre. He was diagnosed and managed appropriately according to his condition and was referred to a specialist at an outside hospital to help control his angina. Staff were encouraging and supportive throughout his time at Hull, putting in place care plans and reviewing strategies to help him receive his medication. The clinical reviewer considered that "he received better care in some ways when compared to community care".

87. Although staff did not take a defibrillator with the emergency bag the resuscitation procedures were quick and controlled. Extensive attempts to revive the man were made by all staff, including ambulance and hospital staff.

88. I am satisfied that the man's care was at least the equivalent of that which he could have expected in the community and that when he was discovered unresponsive, staff generally followed the appropriate procedures in an effort to resuscitate him.

RECOMMENDATIONS

1. The Head of Healthcare should remind all staff where the defibrillator is kept and that the emergency bags should be taken to all code blue alerts.

   The recommendation was accepted and the response was:

   "All healthcare staff are aware that there are emergency bags available on all wings, and an emergency bag is taken to all code blues.

   "We provide regular up date training and have added the location of each defibrillator to all emergency bags."

2. The Governor and head of Healthcare should consider reviewing basic life support training and ensure that on every shift there are wing staff trained to carry out life support.

   The recommendation was accepted and the response was:

   "All healthcare staff has yearly training updated on basic life support. This is via the prison training department.

   "The prison has a number of unified staff trained in first aid across the whole establishment. trained HCC staff are on duty 24 hours a day which include nights."

3. The Head of Healthcare should consider training emergency response nurses to pass a summary of the patient's condition to the ambulance service via an officer.

   The recommendation was accepted and the response was:

   "The nurse attending the prisoner will handover to ambulance staff and explain what has been completed. We also use the same IT system which is accessible at the main hospital where all patients are taken."