PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

Investigation into the death of a man at HMP North Sea Camp in June 2012.

Report by the Prisons and Probation Ombudsman for England and Wales

November 2012

This is the report of an investigation into the death of a man. He died in his room at HMP North Sea Camp in June 2012. He was 59 years old. The cause of death was established by post mortem examination as lobar pneumonia due to chronic obstructive pulmonary disease (COPD). I offer my condolences to his friends.

The investigation was carried out by an investigator. A review of the man's clinical care in custody was completed by a clinical reviewer on behalf of the local Primary Care Trust. North Sea Camp co-operated fully with the investigation.

The man was not offered the anti-pneumonia vaccination recommended by the NHS for people with COPD or asthma. However, I cannot say whether this vaccination might have prevented his death as it is not known whether the infecting bacterium is one which the vaccination protects against. Nevertheless, we recommend that the vaccination is offered to all prisoners at North Sea Camp with respiratory conditions, in line with national guidance.

As I have found in another recent investigation at North Sea Camp, there was a delay in calling an ambulance for the man and the prison staff who responded to the emergency were not trained in resuscitation techniques. Whilst he had been dead for some time and, therefore, neither weakness would have affected the outcome, these issues might be vital in a future case.

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.

Nigel Newcomen CBE
Prisons and Probation Ombudsman **November 2012**

CONTENTS

SUMMARY

1. The man had been in prison for 36 years when he arrived at North Sea Camp in December 2009. At the time of his move he had been diagnosed with high blood pressure for a number of years and had been prescribed medication to treat this. However, he chose not to take this medication due to problems with the supply at his previous prison, HMP The Verne, and his own doubts about its effectiveness.

2. In February 2011, the man complained of shortness of breath on several occasions and was diagnosed with chronic obstructive pulmonary disease (COPD, a term that encompasses a number of lung disease including chronic bronchitis and emphysema). Over the course of the year he was prescribed different inhalers to manage this condition.

3. When his breathing difficulties got worse, the man saw a respiratory specialist at a local hospital on 16 January 2012 and was diagnosed with asthma. The consultant made changes to the medication dose in his inhalers.

4. At a follow up appointment with the consultant on 19 March, it was noted that the man was "really struggling" with his breathing and had not been using his inhalers properly. The consultant asked that healthcare staff at North Sea Camp ensure he used his inhalers as prescribed and two appointments were booked at the prison's respiratory clinic. He did not attend either. A prisoner with whom he was close friends said this was because the man did not trust prison healthcare staff as he thought they had wrongly diagnosed him. In addition, he was now working in the community and had to choose to miss a day's work if he was to go to these appointments.

5. The man was admitted to hospital on 4 June, after reporting increasing shortness of breath. He returned to prison later that day and told healthcare staff and a friend that he felt much better, having apparently been given injections to aid his breathing. No discharge summary was received from the hospital, and on other occasions they took several weeks to arrive. We recommend that the Head of Healthcare liaise with the local hospital trust to ensure timely receipt of such documents.

6. One morning in June, the man's friend told prison staff that he could not wake him. The prison staff who responded came to the conclusion that the man had died in the night and did not therefore attempt to resuscitate him. The paramedics who were called confirmed that rigor mortis was present, and we agree that resuscitation was not appropriate. However, there are some lessons that could be learned from the response. Firstly, the prison staff involved were not up to date with resuscitation and first aid training. In line with HM Inspectorate of Prisons' recent inspection, we recommend that all uniformed officers, particularly those who are on duty at night, receive at least annual resuscitation training. Secondly, there was a delay in calling the ambulance and the correct procedures for doing so were not followed. While this would not have made a difference on this occasion, we recommend that all night staff are made aware of local procedures for calling an ambulance at night and that they should do so immediately if there are grave concerns about the health of a prisoner.

7. A post mortem examination found that the cause of the man's death was lobar pneumonia due to COPD. NHS guidance says that anyone who is diagnosed with COPD or asthma should be offered a vaccination against certain strains of pneumonia. There is no indication that the man received or was offered this vaccination. The clinical reviewer comments that it is not known what the infecting bacteria was in his case, and we cannot therefore say whether his death might have been prevented had he received the vaccination. Nevertheless, we recommend that all prisoners with respiratory conditions are offered the vaccination in line with national guidance.

THE INVESTIGATION PROCESS

8. On 25 June 2012, the investigator issued notices announcing the investigation to staff and prisoners. No one came forward with information.

9. The investigator visited North Sea Camp on 2 July. During the visit he saw the room on Llewellin Unit where the man lived, and spoke to the prisoner who lived in the room next door. He also met the Governor and Chair of the local Independent Monitoring Board. He was provided with copies of the man's prison records, including the medical record.

10. He returned to North Sea Camp on 16 August and interviewed three members of staff. He also spoke for a second time to the prisoner in the room next door to the man.

11. A review of the man's clinical care in custody was undertaken by a clinical reviewer on behalf of the local Primary Care Trust. She joined the investigator for the interview with the Head of Healthcare on 16 August.

12. The man had not had any contact with his family since the 1970s, and they could not be traced following his death. The role of next of kin was taken by a Franciscan friar with whom he had been in touch for a number of years. One of the Ombudsman's family liaison officers telephoned the friar on 27 July to explain the purpose of the investigation. The friar said that he understood that the man did not go to three separate medical appointments and asked if we could establish why he did not attend.

13. As part of the consultation process, the man's next of kin received a copy of the draft report. The friar wrote to the family liaison officer and explained that he was satisfied with the findings of the report. The report was also sent in draft to the Prison Service. Their response to the recommendations is included.

HMP NORTH SEA CAMP

14. North Sea Camp is an open prison for category D prisoners near Boston in Lincolnshire. (Open prisons are for those who can be reasonably trusted not to try to escape.) The prison holds up to 420 sentenced male prisoners in six residential units. The man lived in a single room on the first floor of Llewellin unit, for men nearing the end of their sentences. Those prisoners who are assessed as suitable are able to work in the community, either as volunteers (known as community service volunteers, or CSV) or in paid work. The man worked as a volunteer at a charity shop in a town around 20 miles from the prison. At the time of the investigator's visit, around a third of men worked outside of the prison.

15. Health services at the prison are provided by the local Primary Care Trust, and a new healthcare centre opened in 2011. The healthcare centre is open from 7.30am to 6.00pm Monday to Friday and 7.30am to 12.15pm at weekends. There are four GP sessions a week and a number of clinics for life long conditions, including a clinic for prisoners with chronic respiratory conditions.

HM Inspectorate of Prisons (HMIP)

16. HMIP conducted an unannounced short follow up inspection of North Sea Camp in April 2012. The Inspectorate found that the prison fulfilled its core function relatively successfully and there had been some improvements in the standard of health services. While all nursing staff were up to date with their resuscitation and defibrillation training, the Inspectorate found that this was not the case for all officers. They recommended that all uniformed officers should have at least annual resuscitation and defibrillation training. The Inspectorate also recommended that systems be introduced to ensure that health services staff receive information on care received by prisoners when they have attended external health appointments.

Independent Monitoring Board (IMB)

17. Each prison has an Independent Monitoring Board of unpaid volunteers from the local community who monitor all aspects of prison life to help ensure that proper standards of care and decency are maintained. The most recent IMB annual report for North Sea Camp covers the year to 29 February 2012. The IMB noted that the new, purpose built healthcare unit was a huge improvement. However, there were concerns that its location could be a problem for some prisoners who were too ill to walk or who were physically disabled.

Previous deaths at HMP North Sea Camp

18. Until May 2012, no prisoners had died at North Sea Camp since 2007. Three prisoners then died within a month of each other. The man was the third of these, all of whom died of apparent natural causes. Our investigation into the first of these deaths was critical of the poor emergency response after the man who died collapsed. The emergency response in the second case was much better.

KEY EVENTS

19. The man was sentenced to life imprisonment in 1973. He spent time in various prisons before moving to HMP The Verne in 2004. During his time at The Verne, the man was treated with medication for high blood pressure. In July 2006, he stopped taking his medication. He said this was because his blood pressure was not under control and he did not therefore think the medication was effective. He did not restart his medication for over a year, until December 2007.

20. In May 2009, the man told a prison doctor at The Verne that he had decided to stop taking his blood pressure medication again. He said this was because his repeat prescription was always delivered late. The man told the doctor he had discussed this with someone from the British Heart Foundation and was aware of the risks. In October, he told a nurse that he was willing to restart taking blood pressure medication. He was prescribed a course of candesartan. Later entries indicate that the man stopped taking this medication some time before Christmas, although the exact date that he stopped is not clear from the notes.

21. In November 2009, the man received a routine influenza vaccination. A month later, on 16 December, he moved to North Sea Camp. This was a progressive move, to enable him to live in an open prison and, once assessed as suitable, spend time visiting and working in the local community before his potential release.

22. A nurse carried out a reception healthscreen when the man arrived at North Sea Camp. No mention was made of his history of high blood pressure, or of his recent decision not to take his medication. The man said that he did not have any concerns about his health. No check was made of his blood pressure. The reception healthscreen form includes a 'tick box' section in which it is recorded which vaccinations the patient has received. The box referring to the pneumococcal vaccine was not ticked, indicating that he had not had this vaccine. (This is a vaccination that protects against 23 strains of a bacterium that can cause several serious conditions, including pneumonia.) It was recorded that the man smoked 30 cigarettes a day.

23. The man settled into life at North Sea Camp and began working in the kitchen. He had little significant recorded contact with healthcare staff in his first nine months at the prison, other than a mental health assessment prepared for a probation report which indicated no concerns. On 5 October 2010, a prison nurse checked his blood pressure. The reading was 180/110, which is considerably higher than the normal range. The man told the nurse that he had not taken his blood pressure medication since before Christmas. The nurse recorded that she had told him of the dangers of high blood pressure and strongly advised him to restart his medication.

24. On 13 October, the man saw a prison doctor to discuss his decision not to take his medication. The doctor concluded that he was "well informed and of sound mind" and recorded that he preferred not to take medication. The doctor noted that the man was pursuing lifestyle choices to reduce his blood pressure, although the specific measures he was taking were not recorded.

25. At the next check, on 4 November, the man's blood pressure was recorded as 150/100. While lower than the previous reading, this was still above the normal range. The man told the healthcare support worker who took the reading that he was happy with his blood pressure as it was and did not want to be monitored any more in future.

26. On 12 February 2011, the man saw the prison's respiratory nurse after experiencing shortness of breath. He said he had been short of breath for around 15 years. The nurse performed a spirometry (a test of how well the lungs are working), the results of which indicated moderate chronic obstructive pulmonary disease (COPD encompasses a number of lung diseases including chronic bronchitis and emphysema. Patients with COPD have trouble breathing due to long term damage to the lungs, usually on account of smoking). She recorded that the man "does not appear short of breath". The nurse noted that the man had a GP appointment to discuss stopping smoking, although there is no indication from the records that this appointment went ahead.

27. The man had no further recorded contact with prison healthcare staff until 8 August. He then saw the Head of Healthcare and reported shortness of breath which was worse when lying down. The Head of Healthcare carried out various examinations and noted that the man's chest sounded wheezy and crackly. The man said he smoked 15 cigarettes a day, meaning he had halved his intake since he came to the prison. The Head of Healthcare prescribed a salbutamol inhaler. (Salbutamol is medication that relaxes the muscles in the airways to ease breathing for patients with asthma or COPD. The clinical reviewer comments that salbutamol is effective at providing acute relief for breathing difficulty in both asthma and COPD, but has no effect on preventing relapses and exacerbations.)

28. The following day, 9 August, the Head of Healthcare reviewed the man, who reported little change from the previous day. The Head of Healthcare noted that he would discuss the man's symptoms with the prison doctor. The doctor recommended a chest X-ray, and a request was sent to hospital on 10 August.

29. The man attended the prison's respiratory clinic 19 August, and told the respiratory nurse that his breathing had recently deteriorated and, as it was worse when lying down, he now slept in a chair. He also said that he now had to do daily activities more slowly than previously. The nurse performed a spirometry, which showed improved results since he had started using salbutamol.

30. The man had his chest X-ray at hospital on 1 September. As he was a category D prisoner, he was released on temporary licence to attend this and all future medical appointments. (Release on temporary licence [ROTL] is a form of release usually used to enable prisoners to participate in activities outside the prison that directly contribute to their resettlement into the community or for other special purposes.) The results of the X-ray showed he had overinflated lungs with some suggestion of COPD.

31. On 23 September, the man had an appointment with a prison doctor to review the results of his X-ray. The doctor advised him to continue using the salbutamol inhaler, and he also prescribed a tiotropium inhaler (tiotropium is used to treat COPD by opening the air passages in the lungs to allow air to flow more freely).

32. The man started voluntary work at a charity shop in Spalding, around 20 miles from the prison, in October. He worked five days a week (Monday to Friday), leaving North Sea Camp at 8.00am and returning around 4.30pm to 5.00pm.

33. On 12 October, the man saw a nurse for a review. He said he now smoked six to eight cigarettes a day, but declined smoking cessation support to reduce the amount further. The man also said that he had made changes to his diet and did a lot of walking every day. He reiterated that he stopped taking his blood pressure medication due to problems at The Verne. The nurse took the man's blood pressure which, at 145/97 was slightly above the normal range.

34. A follow up appointment with a prison doctor was booked for 28 October. However, the man did not attend, for reasons which are not recorded. He attended a rebooked appointment on 22 November, when the doctor noted that the man was becoming increasingly short of breath despite using two inhalers. The doctor added a symbicort inhaler to the man's medication. (Symbicort contains a steroid to reduce inflammation and another drug to relax the air passages in the lung. The two ingredients work to keep the airways open and make it easier to breathe. The clinical reviewer comments that symbicort is effective for both symptom control and preventing exacerbation in both asthma and COPD.)

35. The doctor referred the man to a respiratory physician at the hospital. The man was unable to attend an appointment on 12 December, as he was on home leave at the time. (Prisoners who are assessed as suitable are able to take home leave to visit family or another authorised address to help their preparation for release.) The appointment was rebooked for 16 January 2012. In the meantime, he did not attend an appointment at the prison's respiratory clinic on 6 January. The reason is not recorded. He saw the consultant respiratory physician on 16 January, who diagnosed asthma rather than COPD. He recommended that the man stop taking tiotropium and increase the use of his symbicort inhaler to twice a day.

36. The man did not attend an appointment at the prison's respiratory clinic on 2 March and missed several other appointments over the next few months. A friend of his, who lived in the room next door, told the investigator that the man preferred to go out to work than to attend these clinics. The man's friend said this was mainly because the man did not trust prison healthcare staff as they had told him he had COPD when he was later diagnosed with asthma by the consultant.

37. The man saw the consultant respiratory physician again on 19 March, who described him as "really struggling" and observed that he had not been using his symbicort inhaler and was using the salbutamol inhaler excessively to compensate for this. In his discharge letter, the consultant asked prison

healthcare staff to ensure that he used his symbicort inhaler as prescribed and advised the addition of another medication if his asthma was still not well controlled. The letter was typed at the hospital on 17 April and arrived at the prison on the same day.

38. The man did not attend two appointments at the prison's respiratory clinic, on 8 May and 15 May. He went to the healthcare centre on 4 June to collect a new salbutamol inhaler, but was told there were none in stock. He also said he had been experiencing difficulty breathing. The duty nurse contacted the hospital for guidance and was advised that he should be admitted for assessment.

39. He returned to North Sea Camp that afternoon. We have not seen any correspondence from the hospital relating to this, but he told the duty nurse, on 5 June, that he had been given an injection to aid his breathing and was treated with nebuliser therapy (a nebuliser is a machine that creates a mist of medication, which is breathed in through a mask or mouthpiece). It also appears that he was prescribed an additional medication, budesonide, for the treatment of asthma.

40. The next morning, on 6 June, the respiratory nurse reviewed the man, who said that his breathing was now "100 per cent". She offered him a spare inhaler to ensure that he did not run out again, but the man said he did not want to take it as he was afraid he would fail a check for having too much medication. The nurse explained that this would not be the case, but he still said he did not want the additional inhaler.

41. It does not appear as though the man had any further contact with healthcare staff. His friend said that the man appeared to be much better when he came back from hospital. He continued to work at the charity shop in Spalding, and told his friend that he had passed a managerial course and had been offered paid work there.

42. As he normally did, the man spent the evening of 21 June chatting with his friend in his friend's room. His friend recalled that the man was making a "clicking" noise when he breathed, but he did not appear to be struggling for breath and he said he was all right. The man also had a cough, which his friend said was not unusual for him. At around 10.20pm, the man returned to his room as normal. His friend recalled hearing him go to the bathroom around ten or 15 minutes later and heard no further sound from his room overnight.

43. An Operational Support Grade (OSG, the grade below prison officer) was on duty in Llewellin unit on the night of 21-22 June. The OSG told the investigator that he saw the man at roll check at around 9.30pm on 21 June. He recalled that the man seemed his normal self and there was no indication that he was in pain or having any difficulty breathing. The OSG said it was a very quiet night and he had no reason to see the man through the night.

44. The man's friend woke at around 5.30am on 22 June. They usually had tea and coffee together in the morning before they went to work and, at around 5.45am, the man's friend knocked on his door as usual. There was no response. At

around the same time, the man's friend heard the man's alarm go off. He told the investigator that this was unusual because the man did not normally sleep in. At around 6.00am, the man's friend knocked on the man's door for a second time, and still received no response. He returned to his room to get ready for work.

45. At around 6.15am, his friend knocked on the man's door for a third time. When he again received no response, he returned to his room and knocked on the wall between their rooms (which he said was very thin). Again, there was no response. The man's friend then looked through the window flap in the door into the room. He described the man as lying in bed and looking asleep. After knocking again, he went to the unit office and told the OSG that he could not wake the man.

46. The OSG recalled that it was around 6.28am that the man's friend came to the office. In line with local procedures, he telephoned the night orderly officer (a senior officer who is in charge of the prison on site overnight) to ask for permission to unlock the man's room. The night orderly officer was a Senior Officer (SO). He gave the OSG permission to proceed, and recalled that this was at around 6.30am.

47. The OSG went into the man's room immediately. He described the man's condition as follows:

> "[The man] was laid on his back … he had no colour whatsoever, his face looked ever so waxy. He was clenching his arm to his chest. [From] my limited knowledge I knew he was deceased … all the blood had just drained away."

48. The OSG did not check the man for signs of life. He left the room and radioed the SO to ask him to come to the unit. The SO arrived at Llewellin unit at around 6.35am and went straight to his room. He described the man's condition as follows:

> "I felt his wrist and it was cold, clammy, no pulse. I put my fingers on his neck [and found] no pulse … There was no sign of breathing, he was cold to the touch … I knew he had passed away some time ago."

49. The SO also told the investigator that he thought rigor mortis (the stiffening of the body after death) had begun to set in. He then left the room and returned to the gate to telephone for an ambulance but was unable to connect the call. The SO therefore telephoned another OSG on the North Unit and asked him to make the call, which was made at around 6.38am.

50. Ambulance service records show that the paramedics arrived at North Sea Camp at 6.52am. The SO took them to the man's room, which had remained locked since he had left around 15 minutes earlier. The paramedics' notes record that rigor mortis was present and there was widespread lividity (the process by which blood, as it is no longer being pumped around the body by the heart, settles in response to gravity). The paramedics did not attempt to resuscitate him.

51. Later in the morning, the SO and two OSGs attended a debrief with the prison's Governor. A member of the prison's care team spoke to each member of staff involved to offer support. The Governor went to Llewellin to speak to the man's friend and asked staff on the unit to ensure they supported him.

52. The man had not had any contact with his family since he was sent to prison in 1973. No records were held of their whereabouts and they could not be traced. The contact details of a lady from a Christian Fellowship, with whom he had been in touch since he was in a prison close to her home, were found in the man's telephone records. One of the prison's family liaison officers telephoned her on the afternoon of 22 June to let her know that he had died. A Franciscan friar with whom he had been in contact subsequently assumed the role of next of kin.

53. The funeral was arranged for 23 July. The man's friend and representatives of the prison attended. The prison arranged and paid for the funeral in line with national guidance.

ISSUES

Provision of pneumococcal and influenza vaccinations

54. NHS guidance recommends that persons aged over 65 or those who fall into certain risk groups should receive the pneumococcal vaccination. This is a vaccination that protects against 23 strains of a bacterium that can cause several serious conditions, including pneumonia. The at-risk groups who should be offered the vaccination include persons with long term respiratory conditions, such as COPD or asthma. The vaccination is given just once and, for most adults, offers protection for life.

55. The Head of Healthcare at North Sea Camp told the investigator and clinical reviewer that the pneumuoccoccal vaccination is offered to all patients with respiratory conditions. However, there is no evidence from the records that the man was offered or received such a vaccination.

56. The cause of the man's death, established following post mortem examination, was lobar pneumonia due to COPD. The clinical reviewer has considered whether provision of the pneumococcal vaccination might have prevented his death. She comments that the vaccination does not protect against all pneumonia causing bacteria. HM Coroner for South Lincolnshire has indicated that the pathologist who carried out the post mortem examination did not take the required lung samples that would have identified the micro-organisms that caused his pneumonia. It is therefore not possible to know whether the vaccination could have helped prevent his death.

57. There is also no indication in his records that the man was offered or received the annual influenza vaccination at North Sea Camp. Again, this should be offered to persons who fall into certain risk groups, including those with asthma or COPD, who are at greater risk of developing complications of flu (such as pneumonia).

    The Head of Healthcare should ensure that patients with respiratory conditions are offered the pneumococcal vaccination and the annual influenza vaccination.

The man's compliance with recommended treatment and clinics

58. Although the clinical reviewer comments that the man "did not receive optimal care" for his blood pressure or respiratory problems, she recognises that this was largely due to his failure to attend review appointments or fully comply with his prescribed medication.

59. The man had been prescribed medication to treat his high blood pressure for a number of years. He stopped and restarted this medication on several occasions but made a clear decision not to take it at North Sea Camp. He was also sometimes reluctant to have his blood pressure checked. The risks were explained to him and he made an informed decision about his treatment.

60. The clinical reviewer comments that the key intervention to improve outcomes and prolong life for patients with COPD is stopping smoking. The man was offered help to stop smoking via the prison's smoking cessation clinics, but chose to reduce his cigarette intake by himself. He said he had reduced his cigarette intake from 30 a day when he first came to North Sea Camp to six to eight a day by October 2011. He continued to smoke until his death. The clinical reviewer comments that the man's "long and heavy smoking history would have significantly contributed to the severity and apparent rapid progress of his COPD".

61. There is a suggestion that the man did not use his inhalers correctly. At a hospital clinic in March 2012, it was noted that he was not using his symbicort inhaler and was compensating by using salbutamol excessively. Symbicort was first prescribed by a prison doctor in November 2011, with the dose increased by the consultant in January 2012. The consultant asked that healthcare staff at North Sea Camp ensure the man took his inhalers as prescribed. The man collected his inhalers regularly but we do not know how effectively he used them. Appointments were made for him at the prison's respiratory clinic on 8 May and 15 May, neither of which he attended. The man had also missed his two previous appointments at the clinic, on 6 January and 2 March. The clinical reviewer comments that he only appears to have attended healthcare when his symptoms were particularly severe (such as on 4 June, when he was admitted to hospital following difficulty breathing).

62. The man's friend told the investigator that the man trusted the advice of his consultant rather than prison doctors, on the grounds that he believed prison doctors had wrongly diagnosed him with COPD whereas the consultant had diagnosed asthma. (The post mortem report indicated that the man had advanced COPD.) The man also preferred to go to his job in the community rather than take time off to attend prison clinics. He missed most of his prison clinics after he started working in the community in October 2011, although he attended hospital clinics.

63. North Sea Camp runs a number of clinics for prisoners with life long conditions. All are run on weekdays and the respiratory clinic, with which the man was registered, runs on Thursday afternoons. The healthcare centre is open in the morning at weekends, but runs a limited service with just two staff on duty. The man worked from Monday to Friday and, therefore, had to choose whether to go to work or miss a session in order to attend the prison's respiratory clinic.

64. Around a third of prisoners at North Sea Camp work outside the prison, either as community service volunteers or in paid employment. While the clinical reviewer suggests that routine appointments for review of long term conditions should be made available seven days a week we agree with the Head of Healthcare that this would not be possible to provide, particularly when specialist trained staff are required for certain conditions. North Sea Camp has a resettlement function for long term prisoners and we do not consider it is unreasonable to expect prisoners with long term health conditions to take some responsibility for their own health and balance the need to attend appointments with their work commitments, as they would be expected to do in the community. The prison

has indicated that prisoners can be compensated for any lost prison pay as a result of attending clinics or other healthcare appointments.

Communication with the hospital

65. When the man attended an appointment at the hospital's respiratory clinic on 19 March 2012, the discharge letter, which advised healthcare staff to ensure he took his medication correctly, was not received at the prison until 17 April, nearly a month later. When he was admitted to hospital on 4 June, no discharge documents were received at the prison before he died two and a half weeks later.

66. The inspection of North Sea Camp in April 2012 noted that health services staff at the prison usually received discharge letters when a prisoner stayed overnight in hospital. However, they did not always receive information from outpatient appointments or from accident and emergency departments. The Head of Healthcare explained that one problem is that discharge letters are usually issued electronically by the hospital in a format not compatible with the software in use at North Sea Camp. He explained that prisoners are now sent to hospital with a letter asking for a hard copy of the discharge summary. He said that the response to this is inconsistent and discussions are ongoing.

67. While we acknowledge that this is a problem to a large degree outside the control of prison healthcare, it is essential that, as care providers, they have up to date information about a patient's diagnosis and treatment. We endorse the recommendation of the clinical reviewer:

    The Head of Healthcare should liaise with the NHS Trust to ensure the timely receipt of discharge summaries and outpatient correspondence.

Emergency response

68. Both the OSG and SO told the investigator that they thought the man was dead when they were alerted on the morning of 22 June. From his examination of the man, the SO thought that rigor mortis had set in. This was confirmed by the paramedics on their arrival. Rigor mortis is the stiffening of the body after death, and normally appears around two hours after the deceased has passed away. Both the SO and OSG told the investigator that they did not consider cardiopulmonary resuscitation (CPR) as they were certain that the man had been dead for some time. The evidence of the paramedics confirms this. We agree that it was correct not to attempt to resuscitate the man.

69. There are, however, some areas in which the response to the man's death might be improved. Although he was correct to conclude that the man had been dead for some time, the OSG did not examine him for signs of life as he should have done. In addition, neither the SO nor the OSG were up to date with first aid or resuscitation training.

70. The April 2012 inspection recommended that all uniformed officers should have "at least annual resuscitation and defibrillation training". Although this report was

issued after the man's death, the Inspectorate was repeating a recommendation from a previous inspection in 2009. We have made a similar recommendation following the death of a prisoner at North Sea Camp in May 2012. (The draft report into this prisoner's death was issued after this death.) We consider it vital that night staff at North Sea Camp, who are unable to call on the expertise of on-site healthcare staff, have the training and skills to respond to a medical emergency. We therefore make the same recommendation:

The Governor should ensure that all staff have at least annual resuscitation and defibrillation training so that they are able to respond appropriately to an emergency.

71. After examining the man, the SO left Llewellin unit to go to the gatelodge to telephone for an ambulance. He had difficulties making the call and therefore telephoned the OSG on the North Unit and asked him to contact the emergency services. The SO later told the investigator that there is a delay of around 30 seconds (rather than an instantaneous connection) when you telephone '999' from the gate, which he was not aware of at the time.

72. Summoning an ambulance at night in an emergency should be done by radio call to the North Unit, from where the OSG on duty will telephone the emergency services. This should be done as quickly as possible and the radio call can be made from the cell in which the incident has taken place. In February 2011, the Chief Executive Officer of the National Offender Management Service (NOMS, the organisation responsible for the Prison and Probation Services in England and Wales), wrote a letter to governors in response to a report issued by this office in relation to deaths from cardiac diseases. He reminded governors that of previous guidance issued in 2004 and said that:

> "It is also essential that internal procedures should not waste undue time in summoning emergency assistance … The most important aspect of emergency care is that an ambulance is called in all cases where there are grave concerns about the immediate health of a prisoner."

73. The man had seemingly been dead for some time before prison staff were alerted, and there is no doubt that it would have made no difference if an ambulance had been called when he was first found. However, in other circumstances the timing of the call to the emergency circumstances could be vital and it is essential that night staff are aware of local procedures.

The Governor should ensure that all night orderly officers and operational support grades are aware of local procedures for calling an ambulance at night and understand that they should call an ambulance immediately whenever there are grave concerns about the health of a prisoner.

CONCLUSION

74. The man had been diagnosed with respiratory problems in February 2011. Although he cut down on his cigarette consumption, he continued to smoke. The man did not always attend respiratory clinics to monitor his condition. Although he was in a risk group, there is no record that he was offered a vaccination for pneumonia. Unfortunately, the post mortem report did not identify the bacterium that caused the infection, and we cannot therefore say whether the provision of this vaccination might have made a difference. Nevertheless, these events serve as a reminder of the importance of offering such potentially crucial vaccinations.

75. It is apparent that the man had been dead for some time when he was found and we believe it is right that prison staff did not attempt to resuscitate him. However, this investigation identified, as others have done, a lack of training in resuscitation techniques. North Sea Camp does not have healthcare cover at night or throughout the weekend so it is important that all prison staff are able to respond effectively in an emergency.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that patients with respiratory conditions are offered the pneumococcal vaccination and the annual influenza vaccination.

   Accepted - Respiratory patients are offered Pneumococcal vaccines. We are looking to ensure that the documentation of such is more robust. Pneumococcal vaccine is identified on the reception screen and flu and we are looking at ways that the electronic system can identify those in need and place straight onto the waiting list. Flu vaccines are offered to all at risk patients and are carried out annually.

2. The Head of Healthcare should liaise with the NHS Trust to ensure the timely receipt of discharge summaries and outpatient correspondence.

   Accepted - Liaison with the Trust's diversity manager has taken place and we were assured that this would not happen regularly. However we have now produced a proforma that will be sent with each prisoner to hospital for completion by the hospital/outside provider so that we can hopefully obtain information needed for continuity of care. This has also been discussed at prison steering group and recommended by the healthcare manager at NSC that LPFT senior managers discuss with Trust senior managers. IMB also aware and taking forward.

3. The Governor should ensure that all staff have at least annual resuscitation and defibrillation training so that they are able to respond appropriately to an emergency.

   Accepted - Defibrillators are now in place and training has begun. The Governor will ensure that all staff receive the training and receive refresher training annually.

4. The Governor should ensure that all night orderly officers and operational support grades are aware of local procedures for calling an ambulance at night and understand that they should call an ambulance immediately whenever there are grave concerns about the health of a prisoner.

   Accepted - LSS 2.87 will be reviewed and reissued to ensure that all night staff are aware of the requirements and procedure for calling an ambulance when there are concerns over the health of a prisoner.