The death in custody of a prisoner

at HMP Whitemoor in May 2004

Report by the Prisons and Probation Ombudsman
for England and Wales

March 2005

This is the report of an investigation into the circumstances of the death of a prisoner at HMP Whitemoor in May 2004.

All deaths of prisoners in custody are investigated, including those due to natural causes. The responsibility for carrying out these investigations traditionally fell to the Prison Service itself, but has now been passed to the Prisons and Probation Ombudsman (PPO) to bring independence and greater consistency to the task.

In this case, the investigation has been carried out by the Deputy Ombudsman, Assistant Ombudsman and an Investigator. An independent clinical review was conducted by the Deputy Ombudsman.

My colleagues and I would like to extend our condolences to the man's family for their loss. We would also like to thank the Governor in charge of Whitemoor Prison at the time of our visit, and the other members of his staff who assisted us for their help. We found staff helpful and co-operative.

Stephen Shaw
Prisons and Probation Ombudsman

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Summary

The man was 59 years old when he died from an apparent asthma attack in the early hours of the morning in May 2004 whilst in the care and custody of HMP Whitemoor.

This was the man's only custodial sentence; he was sentenced to life imprisonment in 1994 and was appealing against his conviction. At the time of his death he remained a Category A prisoner which affected timely access to him during the early hours of the morning he died.

The man who died was well known to staff at Whitemoor Prison as a result of the length of time he had been there, and particularly to the healthcare staff who had dealt with many of his health problems.

The man was in poor health and had been for some time. He suffered from ischaemic heart disease, bronchial asthma and chronic obstructive airway disease (COAD) and was frequently seen for chest and bronchial infections. On the evening before he died the man was seen by a health care worker following a message received from residential staff that he had chest pain. In the early hours of the morning he died, the man rang his cell bell requesting medical assistance. He subsequently collapsed and was pronounced dead. The primary cause of death was later given by the pathologist as acute asthma, with a secondary cause as ischaemic heart disease.

The Deputy Governor wrote to the man's wife offering his condolences and attended the funeral. She was contacted by one of our Family Liaison Officers and discussion was had about the report. She had no questions or particular concerns at that time.

Background

HMP Whitemoor is a high secure prison and as such there are various security measures that are undertaken before a prisoner of category A status can be unlocked at night. The procedures for unlocking a category A prisoner in case of serious self harm or injury in HMP Whitemoor state that staff may enter a cell alone to save a life, but are reminded that they must ensure their own safety and ensure keys and radio's are safe.

The man who died was known to staff as being of good behaviour and not causing any problems. This was documented in his wing file by his personal officer, and in a review of his category A status on in May 2004. The man remained a category A status prisoner due to his denial of offence and difficulties in assessing the risk he may pose outside of prison conditions. He had no security incident reports written about him and no adjudications.

All the indications are that this was a death from natural causes. The Ombudsman's Terms of Reference permit in these circumstances, that it may be sufficient for a clinical review to be carried out by an independent health care professional, rather than a full investigation. My approach in cases of apparent natural cause deaths has been to conduct an initial review to determine if a full investigation is justified. In the man's case, I decided that the circumstances did require a full investigation.

Chronology of events in the weeks leading up to the man's death

The man who died was a regular visitor to healthcare and had several overnight stays leading up to May 2004.

x May 01:30	Healthcare called to his cell. The man thought he was having an asthma attack. He was using his nebuliser in his cell, and said he panicked when he couldn't breathe.
x May	He was seen by healthcare staff after another attack.
x May	Entry in IMR
x May	He was seen by healthcare staff because he had a tight chest.
x May	The man was seen twice on this day. He was seen on the wing by healthcare as special sick due to having chest pain, and was using his nebuliser

Chronology of events during the incident on the day he died

02:02	The man rang his cell bell
02:03	The cell bell was cleared
02:12	From 02:12 to 02:25 Category A prisoner checks were conducted by wing staff
02:16	He was visited for a category A check
02:18	The man's personal officer informs a nurse and principal officer that he needs medical attention.
02:22	The officer contacts Healthcare again to inform of renewed seriousness of the man's condition.
02:23	The officer contacts the principal officer regarding renewed seriousness of situation.
02:25	The principal officer contacts a senior officer.
02:27	Ambulance is requested. Dog Handler is requested.
02:28	The principal officer, senior officer, the man's personal officer, a Dog Handler and a nurse enter the man's cell. The nurse commences resusitation.
02:30	A Doctor is called.

02:45	The Doctor and ambulance arrive at prison.
02:55	The Doctor and ambulance arrive on wing.
03:00	The man is pronounced dead.

The man's healthcare needs

The man who died suffered from ischaemic heart disease, Chronic Obstructive Airways Disease (COAD) and bronchial asthma. Over his time in custody he had attended several outside hospital appointments over the years. The last, and only outside hospital appointment in 2004 was on 28 April which included an overnight stay.

From the beginning of April 2004 till the day of his death, there were 14 entries in his Inmate Medical Record (IMR). Most of these were due to the man's shortness of breath and chest problems. He was seen as special sick in healthcare, and on the wing and stayed on the healthcare centre for two nights from 12-14 April 2004. There is no doubt that medical staff were well aware of the man's health needs.

Amongst other visits, healthcare staff visited him in his cell early in May 01:30 as the man felt he was having an asthma attack and could not breathe so understandably was anxious. He used the nebuliser he had in cell and staff reassured him thus helping him to calm down. One healthcare officer commented that he often needed his nebuliser and reassurance.

In the week before the man's death he was seen three times by healthcare staff. The prison doctor saw him during that time and was concerned about him and asked him if he wanted to stay the night in the healthcare centre but he declined. Unfortunately this information was not recorded in the Inmate Medical Record (IMR). Two prisoners, interviewed subsequently commented that the man had been upset in healthcare on the day prior to his death.

In the weeks prior to the man's death the prisoners in neighbouring cells collected his meals for him as he struggled to climb stairs without getting breathless and was having difficulties walking.

During the evening before he died health care staff received a message that the man was complaining of chest pain. A member of the health care team attended the wing and saw the man and noted that he was using his nebuliser, but denied any chest pain. He felt the problem was with gastric reflux and so a single dose of gaviscon was administered.

At approximately 02:16 the man's personal officer noted that the man was using his nebuliser and looked unwell and therefore returned to the office to call health care. A nurse attended the wing accompanied by the principal officer and waited in the office until sufficient staff were available to enter the cell. It does not appear that the nurse attended the cell to assess the clinical condition of the man until sufficient staff were on the wing to facilitate the unlocking of his cell door due to his Category A status.

Management of the crisis situation

At 02:02, the cell-bell call log shows the man rang his bell. My investigators checked with a security systems engineer that the times on the cell bell log were accurate, and the engineer confirmed that they were accurate to within two seconds of Greenwich Mean Time. The bell, according to the cell bell log was deactivated at 02:03. One of the man's neighbouring prisoners recalled hearing noise from the man's cell at around this time. To deactivate the bell an officer must go to the cell door. The officer on duty, does not recall this incident, neither does the OSG.

The officer was performing the check of all category A prisoners when at 02:16 he attended the man's cell. It becomes slightly unclear as to what happened next. In the officer's statement to the police, he stated that at this time the man was using his nebuliser but indicated he was alright, then a minute later pressed his cell bell. There is no evidence of the cell bell in the man's cell being activated after 02:03 on the cell bell log.

The officer then ran along the wing and down a flight of stairs back to the wing office and phoned healthcare and spoke to a nurse at 02:18 and explained the situation. It was usual procedure to use the phone and not the radio at night. The officer then phoned Oscar one – a principal officer and again explained the situation. The officer then returned to the man's cell looked through the door flap where he saw that the man was now on the floor, laying on his side, but could see his chest moving. The officer returned to the office and contacted healthcare and the principal officer again to reappraise them of the situation.

The officer said he was aware of night procedures from the night folder. He also said that he is not expected to enter the cell of his own accord and to wait for additional help to arrive. This was confirmed during interview by the principal officer.

Once the principal officer received the call, he and a senior officer went to the wing via healthcare to collect the nurse, as only the principal officer and the senior officer hold keys, except for those in individual officers sealed pouches for emergency access to cells. The nurse was waiting for them with his medical bag that weighs 11 kilograms. The three of them went to the wing. It was a journey that involved the unlocking and relocking of doors over quite a distance.

The principal officer, the senior officer and the nurse arrived at the wing office, and waited a few minutes for a dog handler to arrive, then along with an officer they entered the cell at 02:28. There is no evidence that any further checks were made on the man who died by the staff of the wing or the staff arriving on the wing, including the nurse, from the time the second call was made to health care and the Orderly Officer and the time they entered the cell, a period of some 10 minutes. On entering the cell the man was found in a collapsed state and the nurse immediately commenced resusitation, and the

officer left to contact the control room to ask them to call paramedics and the duty governor.

The control room phoned for an ambulance, the duty governor and the prison doctor. A senior officer went to the prison gate to wait for the ambulance.

The control room log sheet records that the ambulance and duty governor arrived at 02:45. The process for allowing the ambulance to gain entry is that when the ambulance is called they are given a code, which on arrival at the prison they quote. This allows entry, and a senior officer and dog handler then escort the ambulance to the nearest vacinity of the incident.

The prison Doctor stated he arrived before the ambulance. By the time he was allowed through the gate and waited for an officer with keys to escort him it was eight to ten minutes from his arrival at the prison till he arrived on the wing.

The ambulance crew arrived at the wing at 02:56. The ambulance staff attempted to revive the man using a defiblerator but to no avail and he was pronounced dead by the doctor at 03:00.

Once the man had been pronounced dead, the cell was sealed and all contingency plans were correctly followed. All relevant paperwork provided by the prison was to a high standard and level of detail.

Consideration

There are several points worthy of further discussion.

Healthcare provision

My investigators considered whether the man may have been more appropriately situated in the healthcare unit given his chronic medical condition. The prison doctor states he offered this to him but he declined, unfortunately there is no record of this. There would have been a bed available to him had he wanted one. Healthcare staff are instructed that to open the cell if the man was in distress would still have needed the same amount of staff as was needed on normal wing location. We therefore do not know if any time would have been saved had the man been situated in healthcare.

The man's prison medical records indicate that while in prison before the night of his death, that he was being given an appropriate level of medical care. However, there was no formal provision made to assist him in meeting the activities of daily living whilst on the wing, as a result of his poor mobility and chronic chest condition. For example through providing prisoner aides who would act as a paid helper to assist with day to day activities such as fetching meals and helping clean his cell.

In response to emergencies, health care professionals are required to carry a heavy medical bag over a considerable distance to reach the wing. A trolley for the bag had been provided but is difficult to use when the journey involves stairs. Consideration should be given to the provision of some emergency medical equipment being located on the residential units.

Furthermore, one of the nurses conducted resuscitation techniques alone for approximately 25 minutes. It would be advisable for night staff to be trained in basic Cardio Pulmonary Resuscitation techniques, as 25 minutes of CPR alone is physically exhausting and emotionally difficult.

Timeliness of response and unlocking prisoners of category A status prisoners at night

The officer was also the man's personal officer. The man was known to staff, as being "no problem" and they were aware of his chronic medical condition. The officer knows the cell bell only rang once, but is unaware of the time of this bell. This was the first incident of this nature that the officer had had to face and it was clear that he had found it a particularly difficult situation at the time, and it had affected him deeply.

The officer was under clear instructions from the night orderly officer, the principal officer not to enter the cell alone. Once the officer became aware of the man's distress he acted entirely appropriately given his instructions. The officer stayed with the man who died after raising the alarm until he heard gate keys and he then returned to the wing office while they waited for the dog handler. It would be desirable for someone to have remained with the man monitoring his condition until entry of his cell, given the OSG was also in the office and could attend to the arrival of other officers.

The distance the principal officer and the senior officer had to travel to reach the wing via healthcare is quite lengthy, and they covered the distance quickly. However, it is quite possible that they may not have been situated in the night orderlies' office they could have been conducting security checks elsewhere in the prison, which would have meant it would have taken longer to reach the wing. This could prove problematic in future serious incidents.

Different high security prisons operate different practice in terms of unlocking category A prisoners at night. There is continuity on advice of who should be present which includes the night orderly officers and the dog handler, but ambiguity over opening a cell door alone.

Given the fact that the man was a category A prisoner, and the officer's instruction from the principal officer, it is understandable why he did not enter the cell on his own. However, once support had arrived, given the officer's and the nurse's knowledge of the man it is difficult to understand why it was necessary to wait for the dog handler.

The issue of unlocking prisoners at night is complex, full of ambiguity and also has implications for nursing staff. The nurse explained to my investigators how it is difficult when you are relying on others to open the cell door, when as a clinician your judgement is to get into the cell immediately. Furthermore, by saying an individual officer can make that judgement, but having other procedures in place can be confusing, and forces a large decision to be made usually by junior staff.

Conclusions

The man died of an asthma attack and ischaemic heart disease. The medical treatment leading up to his death was satisfactory. However, more could have been put in place in terms of provision for his needs on the wing.

There are some concerns over the length of time taken to enter the man's cell. Whilst I understand and appreciate the security concerns surrounding unlocking prisoners of category A status at night, he was known to be an ill man, in need of regular medical attention, and known to not have caused staff any security concerns. This concern is amplified when we consider the potential delay could be 26 minutes from the time the man pressed his cell call bell to the time his cell was entered.

Once, the officer was aware of the man's distress he acted quickly and appropriately. It is however, concerning once more, that once a Principal Officer, Senior Officer, Officer and a Nurse were present they still waited, albeit for a short time, for a dog handler before they entered the cell. The OSG was in the wing office and could have allowed entry of the Dog Handler onto the wing when he arrived.

The weight of the medical bag, carried over a significant distance was not an easy feat for the nurse. He then entered the cell and carried out resusitation unaided for approximately 25 minutes. He should be commended for his efforts.

Recommendations

Unlocking of prisoners in life threatening situations

A review of the policy for unlocking prisoners during patrol states should be undertaken to ensure that there is timely access in life threatening situations.

Records and record keeping

Record keeping is an integral part of clinical practice. It is a tool of professional practice that should inform the care pathway. It is not an optional extra to be fitted in if circumstances allow.

Staff must be reminded of their professional responsibilities for appropriate, accurate and contemporaneous records.

Location of equipment

Consideration should be given to reviewing the location of emergency medical equipment to ensure that staff are able to access it in a timely manner.

CPR training

All permanent night duty staff should be trained in basic life support to ensure that the medical practitioner attending an incident has appropriate and effective support.