

**Investigation into the circumstances surrounding the death
of a man at Guernsey Prison
in July 2008**

**Report by the Prisons and Probation Ombudsman
for England and Wales**

June 2009

At the request of the Minister for the Home Department, I was invited to investigate the death of a man that occurred at Guernsey Prison in July 2008. Although Guernsey does not fall within my geographical remit, I agreed to investigate the man's death in line with my terms of reference for England and Wales. My office has also developed a protocol for investigating any future deaths at the prison.

The man was found collapsed in his cell in the early hours of 11 July by a member of the prison staff. He had been sentenced to six weeks imprisonment after being found guilty of driving whilst under the influence of alcohol. I join my investigator and my family liaison officer in offering sincere condolences to the man's family and friends for their sad loss.

I wish to thank the Governor of Guernsey Prison and the deputy governor, for making the necessary facilities and information available to my investigator, and for the assistance of the prison's liaison officer.

In the course of the investigation, I asked for a clinical review to be carried out into the care and treatment the man received in custody and I must thank the appointed doctor for his assistance. However, as I judged that further issues should be explored, and as the appointed doctor had since retired, I commissioned a further report from another doctor. This was done with the full agreement of the Governor and Her Majesty's Comptroller. I am extremely grateful to the clinical reviewer.

I have been concerned to read the clinical reviewers judgement that, had the man's medical condition been recognised earlier and more appropriately treated, the likely outcome would have been favourable. That said, I have been pleased to learn from my investigator of the attempts made by prison staff to resuscitate the man. My investigator also gained a favourable view of the relationships between prisoners and staff.

I must apologise for the delay in issuing my report. This has been caused by the need for the second clinical review, and the availability for interview of the medical staff concerned.

My report makes 16 recommendations and identifies three areas of good practice.

Stephen Shaw CBE
Prisons and Probation Ombudsman

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SUMMARY

In June 2008, the man was sentenced to six weeks imprisonment and taken to Guernsey Prison to serve his sentence. When he arrived at the prison, he was assessed by a nurse who found his blood pressure to be raised. She performed an ECG, and the ECG machine's interpretation of his ECG trace indicated the presence of left ventricular hypertrophy (enlargement of the main chamber of the heart). The nurse telephoned an on-call doctor. She gave her advice, and arrangements were made for her to see the man the following day.

After examining the man, the doctor decided on a care plan which included obtaining an electro cardiograph (ECG) and, if necessary, admission to hospital. Over the course of the following two weeks, he had further episodes of chest pain, including prolonged episodes of night time chest pain.

At 12.35am on 11 July, the man was taken ill. The night manager contacted a doctor at the local hospital but, because his symptoms had subsided, it was thought appropriate that he should remain in prison rather than be taken to hospital.

Just over one hour later, the man was seen by an officer sitting in his chair, rolling his head from side to side. The officer called for assistance but, instead of entering the cell to offer help, he left the area to continue with his duties. This was in the mistaken belief that he should not enter a cell alone.

In response to the officer's request for assistance, staff arrived and went into the cell to help the man. Despite their efforts to resuscitate him, members of the St Johns Ambulance Service determined that he had died.

THE INVESTIGATION PROCESS

1. Once my office had been notified and had agreed to investigate the man's death, the investigation was allocated to a senior member of my staff. He was assisted by one of my family liaison officers (FLOs), and later by another of my investigators.
2. Prior to travelling to Guernsey in September 2008, my family liaison officer contacted the man's family. She explained my role and offered them the opportunity to meet her and the investigator. The purpose of offering the meeting was to invite the family to contribute towards my report and to ask any questions they wanted me to examine. The man's wife and son agreed to meet my investigator and FLO when they arrived on Guernsey to begin their investigation.
3. On 8 September, the investigation team travelled to Guernsey to begin their work. The following day, they met a number of managers and staff at the prison to explain my role. Also at that meeting were members of the local Panel of Visitors.
4. In addition to meeting prison staff, at the invitation of the man's wife my investigator and FLO went to the family home. They were made very welcome by the man's wife and her son.
5. During their meeting, the man's wife said the police had been helpful and had disclosed a number of documents to her. These included witness statements. The early disclosure of the police documents has assisted the man's family become well informed about the circumstances surrounding his care in prison. This has also enabled them to consider the additional questions and concerns for my investigation to consider. I trust that my report will help them understand what happened after he was received into Guernsey prison.
6. At the meeting, the man's wife handed my investigators a copy of the "Island of Guernsey Ordinance of the States". (I explain later the purpose of the Ordinance.) She referred my investigators to section 109 which says, "Every officer shall notify the Governor of the case of any prisoner who, whether he complains or not, appears to be out of health or whose state of mind appears to be deserving of special notice and care and the Governor shall forthwith notify any such case to the Medical Officer."
7. My investigator and FLO discussed the wording and implications of the Ordinance with the HM Comptroller. The HM Comptroller took the view that, whilst the Governor is responsible for the prison, it was impractical to expect him to deal with everything that occurs. He was satisfied that the Governor has to devolve responsibility to the most appropriate department. I understand from the Deputy Governor that the document is to be reviewed.
8. On 11 September, before leaving the prison to return to the United Kingdom, the investigator and FLO met the Governor and deputy governor to feedback their initial findings. As part of that feedback, they raised one finding which was

regarded as urgent and requiring immediate attention. It related to night staff accessing cells in an emergency. The Governor accepted the feedback and said he would deal with the matter.

9. At that same meeting, the investigator and FLO discussed the clinical review which they had received from the doctor who had never previously carried out a clinical review in a prison environment. They were concerned that the review did not meet the standard that I expect and that further work would be required. However, as the doctor had by this time retired, he was not in a position to reconsider his report. As a result, the investigator suggested that a new review should be commissioned. It was felt that it would be appropriate to ask a doctor from the United Kingdom who was experienced in conducting clinical reviews to undertake a separate review.
10. The investigator discussed the need for a second review with my Deputy Ombudsman and she in turn contacted a senior public health adviser in the Department of Health, to see if she was able to recommend a suitable person to carry out the work. She recommended someone who agreed to assess the care the man received, and to travel to Guernsey with my investigator for the purpose of interviewing medical staff.
11. On 22 October, my investigator, FLO, and one of my Assistant Ombudsmen met the new clinical reviewer at his surgery. The purpose of the meeting was to brief him and to decide who should be interviewed. It was agreed that he should not see the report produced by the original appointed doctor. However, he has had full access to my investigators' interview transcripts, prison records including the man's medical records, and police interview transcripts and files
12. On 28 October, the clinical reviewer and my investigator went to Guernsey Prison to complete their interviews with medical and prison staff. Unfortunately, when they arrived at the prison, two of the doctors who the clinical reviewer had wanted to interview were unavailable as they were awaiting advice from their medical indemnity provider. The two doctors expressed their willingness to cooperate fully with my investigation and I accept the delay was not of their making. However, another doctor did attend for interview along with the solicitor who had been engaged by his medical indemnity provider.
13. In the afternoon, my investigator, the clinical reviewer, the duty governor, and a Chief Inspector met the HM Comptroller, at his office in St Peter Port. The purpose of the meeting was to brief the HM Comptroller on the progress of my investigation, and to explain the timescales for issuing my draft and final report. It was expected at that stage that the draft report would be issued in January 2009. The HM Comptroller accepted the timescale and suggested that the inquest could possibly be held in March 2009.
14. On 29 October, my investigator met the Governor and fed back the findings from the investigation to that point. The Governor accepted the findings and also confirmed that the urgent finding referred to earlier had since been dealt with. My investigator and the clinical reviewer also met the prison's Healthcare Manager and fed back the findings relating to prison healthcare.

15. On 2 December, my investigator returned to the prison with his colleague and to complete the final interviews and to meet the healthcare staff based in the prison. The following day, the clinical reviewer joined them to complete his interviews with the two doctors who had been previously unavailable. The doctors were accompanied by their legal representative, acting on behalf of the Medical Defence Union. The clinical reviewer was assisted by my investigator.

ISLAND OF GUERNSEY ORDINANCE OF THE STATES 1998 (Amended 2002)

16. The Prison Administration (Guernsey) Law, 1949, as amended, is the legislation governing Guernsey Prison. It addresses the purpose of imprisonment, the Home Department's duties in respect of the prison, and the power to make rules on prison matters by way of Ordinance.
17. The Prison Administration (Guernsey) Ordinance, 1998, and subsequent amendments, have been approved by the States. Amendments have been made to respond to changes in prison best practice and the nature and size of Guernsey Prison.
18. The 1998 Ordinance details how the prison operates on a day-to-day basis, but says little about how this is to be put into practice. Instead, the prison has its own Prison Orders which are approved by the Governor.

GUERNSEY PRISON

19. The current Guernsey Prison is located outside of St Peter Port and was opened in 1989. The Guernsey Prison Service is accountable to the Guernsey Home Department.
20. The prison has a series of small two storey wings all of which are fed from a central corridor. Prisoner movement is mainly confined to the ground floor level. There are nine residential wings designed to accommodate between six and 12 prisoners each, and one wing designed to accommodate up to 44 prisoners. In total, there is sufficient cellular accommodation to provide places for 122 prisoners.
21. Guernsey Prison is unusual in that it is expected under the Prison Ordinance to provide accommodation for every category of prisoner. It holds adults, young offenders, and juveniles, convicted and unconvicted, males and females, vulnerable and mainstream prisoners. Additionally, the prison has been used occasionally for anything up to 72 hours to hold police prisoners pending their first court appearance, although my investigators were informed by the Deputy Governor that this has not occurred for over 12 months.

Police investigations of deaths in custody

22. In Guernsey as in the United Kingdom, every death in prison custody is reported to the police as soon as it is discovered. In the first instance, the police treat the area where the person is found as a potential crime scene and, as part of their investigation, note the names of everyone involved and those who have been in contact with the body. Additionally, they note the identity of all those entering and leaving the cordoned area. It is only when the police are satisfied that the death is not suspicious that my investigators are able to begin their own investigation.
23. In the case of this man, the Chief Inspector confirmed that he was not treating the death as suspicious. He agreed to share with my investigator the police statements that had been taken shortly after the death.

Prison officer grades

24. There are three levels of uniformed officer grades. Prison officers are the front-line supervisory staff and, in the majority of cases, prisoners have first and most contact with them.
25. Senior officers (SOs) are the first grade of managers and act as a reference point for prison officers. SOs are responsible for the day-to-day management of their area, supervising staff and dealing with issues raised by prisoners.
26. Principal officers (POs) are the highest rank of the uniformed staff. They supervise other uniformed staff and have operational responsibility for the prison.

Prisoner Application Forms

27. Prisoners can make written applications for a variety of things, including asking to see a doctor. The forms are self copying in triplicate. One copy is kept by the prisoner whilst the other two go to the prison department to which the application is addressed.

Radio Communication System

Talk Through

28. The system also allows for the radio net to be placed on “talk through”. This means that every person with a radio can hear the full transmissions and not simply the transmission made by the control room radio operator.

Urgent Message”

29. “Urgent message” is a specific radio transmission used in emergencies, usually associated with a potential or actual breach of security. If used, it should attract a pre-determined response from the control room. Under normal circumstances, where medical assistance is required it would not be usual to announce urgent message.

Gate Override System

30. During normal operating procedures, the prison gates are opened one at a time. When a vehicle arrives at the gate, one gate is opened and the vehicle drives in. After the vehicle has entered the vehicle lock, the gate is closed. Once the gate has closed, the exit gate is opened to allow the vehicle to leave the gate lock.
31. During an emergency, the officer controlling the gates can “override“ the system. Overriding the normal operating system allows the officer to open both gates at the same time, and speeds up the entry or egress of emergency vehicles. However, before overriding the gates, the officer must ensure there is another officer sited at the open gates to watch for and prevent escape.
32. At night time, due to the low staffing levels on duty, overriding the gates is not possible. This is because there are insufficient officers on duty to protect the vulnerability of a fully open gate. For this reason, emergency vehicles have had to gain entry or egress in the normal manner of one gate being opened at a time, thus delaying the vehicle’s movement. Since the man’s death I understand that the Governor has reviewed the procedures for emergency access to minimise delays.

Panel of Visitors

33. The Panel of Visitors are an independent group of local people who, under the Guernsey Ordinance, are required to oversee the prison. The panel have access to any part the prison at any time, and access to any prisoner who they wish to see or who asks to see them.

Her Majesty's Chief Inspector of Prisons (HMCIP)

34. Her Majesty's Chief Inspector of Prisons reports on all Prison Service establishments within the United Kingdom. Although Guernsey Prison does not fall within the Chief Inspector's jurisdiction, the Chief Inspector carries out inspections at the invitation of the Home Department.
35. The majority of inspections are pre-announced and allow the prison to be inspected time to prepare. On 27 June 2005, the Chief Inspector carried out a full announced inspection of Guernsey Prison. The inspection was completed on 1 July, after which the Chief Inspector published her report.
36. In her introduction, the Chief Inspector said the inspection exposed serious shortcomings in some basic aspects of care for the diverse group of prisoners held in Guernsey Prison. The inspection found evidence of managers and staff, "doing their best to deliver decent and appropriate regimes, but doing so against the odds". The Chief Inspector went on to say that it was unrealistic to expect the prison to attain the standards expected elsewhere in the British Isles while there was such a diverse population living under the same roof.
37. The Chief Inspector also commented on the application system which she said needed improving. She went on to say that managers and staff deserved credit for struggling with a complex mix of prisoners, for which they were not sufficiently trained or resourced.

FINDINGS

38. In preparation for the man's appearance in court, his Probation Officer wrote a report on 20 June 2008 for Guernsey Magistrates Court. She noted that the man had told her that he was dependant on alcohol and would drink to excess on a daily basis, which he said he had been doing over a ten to 15 year period. The probation officer concluded her report by adding that he was preparing himself for imprisonment, although she did suggest that a Community Service Order was an alternative to his being given a custodial sentence.

26 June

39. On 26 June, the man was sentenced to six weeks imprisonment after pleading guilty to "driving a motor vehicle with excess level of alcohol in breath". After receiving his sentence, he was taken to Guernsey Prison. When he arrived there, he went through the normal procedure for receiving prisoners and his personal information was recorded by a prison officer. As well as noting his personal details, he was seen by the healthcare manager, who completed a First Reception Health Screen (FRHS) document. Again, this is normal practice.
40. During the FRHS procedure, the healthcare manager noted that the man said that, prior to being admitted to prison, he had been experiencing chest pain with exertion. He also told her that he had been an inpatient at an outside hospital about six years previously in connection with his alcohol problems. (The outside hospital is part of the Guernsey Mental Health Service.) Whilst there, he had taken part in an alcohol detoxification programme, but said that he had since returned to drinking alcohol. He told the nurse that he had a history of consuming between 14 and 28 units of alcohol daily. However, he added that he had not consumed alcohol for about one month before going to prison. The man also said he smoked up to 30 cigarettes per day, but later changed this to 40.
41. At interview, the healthcare manager told my investigators that the man said his chest pains were present when walking up a hill close to where he worked. He added that he also felt breathless when doing so. The healthcare manager said that, from the description, the man's pains made her think that he had a heart problem, and that it might possibly be angina. With this in mind, she decided to carry out an Electro Cardiograph (ECG) straightaway.
42. The ECG's interpretive report indicated a presence of Left Ventricular Hypertrophy (LVH) which is an enlargement of the main chamber of the heart. The healthcare manager also found that his blood pressure was raised at 176/90. She also carried out a Vitalograph spirometry test (a lung function test). The test indicated mild obstructive airways disease, which the healthcare manager had anticipated given the man's history of smoking.

43. After completing her tests, the healthcare manager decided to telephone the doctor who was due to attend the prison the next day, to seek her advice. However, the healthcare manager did not make a record her conversation with the doctor in the man's medical notes, nor record that it had taken place. At interview, she confirmed that she had not mentioned her own thoughts of possible angina to the doctor, preferring instead to let the doctor make a diagnosis. She added that the man was not in pain at that time and looked well.
44. The healthcare manager said that the doctor decided there was no need to see the man urgently, and that she would see him the following day. She said the doctor told her that the test results were not acute.
45. In her Reception Health Screen notes, the healthcare manager recorded that the man complained of chest pain in the left thoracic area that the pains occurred once or twice per day on exertion, but could occur when he was resting. She wrote that these pains had been occurring for about six to seven weeks. The healthcare manager also made an entry on the continuation sheet in the main section of the medical record. This entry includes a sentence to the effect that the man had been getting left sided chest pain intermittently for approximately seven weeks, usually on exertion.
46. In her statement to police, the healthcare manager said that "On routine questioning about any problems related to chest pain he stated that he had experienced some intermittent chest pain in his left thoracic area on exertion when sometimes walking up some inclines, but that sometimes the pain could also be experienced when he was resting. He stated that this sometimes could, on occasions, be once or twice per day".
47. The healthcare manager told my investigators that she had discussed smoking cessation with the man. However, due to his short sentence, he would not have the opportunity to join the programme (it is a 12 week course and he would have been released before completing it).
48. As part of the FRHS document, the healthcare manager completed the risk assessment section. Under one of the headings ("Is there an active risk?") she wrote that there was not. After completing the reception procedures, the man was taken by a prison officer to F wing. When he arrived on the wing he was allocated to cell F9.

27 June

49. On 27 June, the man was seen by the doctor for the routine Reception Medical. In her police statement, the doctor said the man had described a cyclical chest pain lasting between seven and ten minutes during the previous seven weeks or more. The doctor said they were left sided thoracic pains, which sometimes occurred when the man was resting and had not been made worse by exercise. The doctor said she planned to recheck his blood pressure the following week after he had settled into the prison and, if the readings remained elevated, then treatment should be started. She said she asked the nurses to begin monitoring him if the pains returned. Knowing that the prison had its own ECG

machine, the doctor said she told the man to alert staff if the pain recurred. If an ECG could be carried out, it would be, otherwise he would need to be taken to the Accident and Emergency Department. (However, there is no reference to the need for an ambulance or admission outside nursing hours in his medical record.) The doctor said she told the man that he might require further tests if the pains continued. She also gave smoking cessation advice, because his risk of cardiac problems was significantly raised by continuing to smoke.

50. At interview with my investigators, the doctor said she could not recall receiving a telephone call from the healthcare manager. However, she later added that she had a vague recollection of writing the man's name onto a "post it note". Additionally, she remembered a reference being made to alcohol problems, high blood pressure and LVH. She could not recall any mention of chest pain and did not believe she had been told of the history of chest pain. She explained that, had it been discussed, she would have requested far more detail and would have expected to be able to recall the conversation.
51. The doctor said that, when she was in the prison consultation room, she had looked at the medical notes made by the healthcare manager. She read that the man had complained of chest pain. The doctor noted that he smoked 30 cigarettes per day and said he had smoked for 40 years. At the same time as the doctor was reviewing him and his medical notes, a nurse was present in the consultation room assisting the doctor.
52. As with her police interview, the doctor told my investigators that the man's chest pain was cyclical, lasting between seven and ten minutes. She said it was a left sided pain and occurred sometimes at rest and was made no worse by exercise. The man gave the doctor an example of walking to his work place from the bus stop. He said he was able to walk through the pain and that it would settle down. (As part of his clinical review, the clinical reviewer has followed the route that the man would have taken to get to his place of work. He found that the walk from the bus stop to the workplace is uphill all the way with a varying degree of incline, and is an ideal test of exercise tolerance for someone with angina.)
53. In her interview with my investigators, the doctor said the man told her that his chest pain typically started as he got off the bus, or shortly after, and that the pain would ease off when he was about half way up the road. At first she thought the pain was musculoskeletal, but on finding no tenderness to his chest wall she decided it was atypical chest pain.
54. On the doctors instructions, a doctor's appointment was made for the following week. In her notes and statement to police, the doctor noted indicated that the appointment was for a review of the man's blood pressure after he had settled in prison, and for a decision to be made on treatment if his blood pressure was still raised. This is in line with normal practice. In her interview with the PPO investigation team, the doctor said that she intended for the duty prison doctor to review the man after a week and for this to be a general review as well as a review of his blood pressure.

55. The doctor said that she had told the nurse that the man should have a series of blood pressure readings in the meantime. The interim blood pressure monitoring by nurses is not recorded in her notes or police statement, and the accompanying nurse arranged for a single reading six days later. She wrote on the Nursing Handover sheet "Repeat BP next week", and put his name in the Nurses' diary for a blood pressure check on 3.7.08.
56. At interview, the doctor said she recognised that angina remained a possible diagnosis, notwithstanding the fact that the pain was not typical of angina. The clinical reviewer says in his report that the pain was atypical, both in its onset as the man got off the bus, but more significantly in that he could walk through the pain.
57. In the man's medical notes, the doctor wrote:

"Repeat BP 1w [meaning repeat blood pressure one week] after settled in prison and if still elevated then for treatment. Also monitor if further chest pains occur and consider treadmill/lx [meaning investigations]. Smoking advice given."

At interview, the doctor said that in her experience a patient would have to wait about six weeks on Guernsey for a treadmill assessment. She said her intention was that the doctor reviewing the man would check his blood pressure and undertake a general review of his health. She said that "monitor" was meant to mean that another ECG should be taken if he had further chest pain. The doctor explained that her rationale for this was that if an ECG could be taken during an episode of chest pain it might confirm or refute a diagnosis of angina.

58. In her police statement, the doctor said she told the man that if the pain occurred when an ECG could be performed, then it would be done. However, if the pain occurred when an ECG could not be performed, he would need to go to hospital by ambulance as an emergency patient. The doctor added that she told the nurse and the man that in the meantime he was to have a series of blood pressure readings, although she did not make any entry to that effect in his medical record. Neither did she record her instructions about the possible need for transfer to hospital in his medical notes.
59. At interview, the nurse who had been present throughout the consultation, said she remembered the doctor saying that there was an abnormality with the man's heart and that it was probably related to blood pressure. She also remembered he being advised to have an ECG if he had further chest pain when nursing staff were on duty. However, the nurse said she had no recollection of the doctor advising the man that he would need to go to hospital if the nurses were not on duty and did not record such instructions in the management plan. (Management plans are the doctor's instructions for what actions should be taken with individual patients.)

60. The nurse made an entry on an appointment handover sheet noting the doctor's management plan that the man was to have a repeat blood pressure check the following week. She also made a similar entry in the nurses' diary for 3 July. At 1.35pm, the Prison Information Management System (PIMS) records the healthcare manager as having made the man's appointment on the computer.
61. Although she said she discussed the management plan with the man, the doctor did not make any record to this effect. She said he told her that, when the pain eased, it was not because he had stopped walking as he could walk through the pain. He also said that he had been under a lot of stress at work and thought it might be linked to his chest pain.
62. The doctor said that her examination showed that the man was mildly hypertensive on two separate readings, had mildly chronic obstructive pulmonary disease, and LVH. She said her impression of him was that of a mildly hypertensive patient, with atypical chest pains and a history of neuralgia (nerve pain).
63. At the end of the consultation, the doctor prescribed the man with a high dose Vitamin B Compound and Thiamine tablets. (The clinical reviewer says this is a normal prescription for treating someone with excessive alcohol use.)

30 June

64. At about 7.45pm, an officer was on evening duty in F wing. At interview, he told my investigators that the man approached him and told him that he needed to be taken to healthcare as he had pain across his chest. The officer said he told him that he was to be taken to healthcare whenever he had chest pains. As the man appeared to be distressed and was complaining of chest pain, the F wing officer escorted him to healthcare.
65. When he and the man arrived at the healthcare department, which is on the upper floor of the building, the nurse was not there. The F wing officer decided to take the man to the medicines treatment hatch as evening medication was being issued. (This is an area where medication is dispensed to prisoners by a nurse.) The F wing officer told my investigators that the man walked "in bursts" and was "hunched up". He thought that he might have to get a nurse to him, rather than him go to the treatment hatch, but in fact he managed to walk to the hatch.
66. When they arrived at the treatment hatch, the nurse was there dispensing the evening medication. At interview, the F wing officer said he spoke to the nurse and told her that the man had chest pain. He said he told her that the man had said that he was to be placed on a monitor if the chest pains recurred.
67. The F wing officer said the man spoke to the nurse and he heard him say that he had had chest pains. He said he told the nurse he had been told that, if the chest pains returned, he needed to be put on a monitor. Additionally, he heard him telling the nurse that the pains had now gone.

68. At interview, the nurse said she did not examine the man because he told her that he felt fine and that he looked well. She said she did not carry out an ECG because she understood that the test might be useful during chest pain but not when the pain had gone. The nurse said she did not know whether or not an ECG would show abnormality after the pain had gone. She added that it was her recollection that the doctor had said it would be useful if an ECG could be done during pain. As he did not have chest pain at that time, she thought an ECG might not have been useful.
69. The nurse noted in the man's medical record that he had had an episode of chest pain which had resolved by the time she saw him. She also wrote "see previous note". The previous note referred to is one written by the doctor on 27 June, "... Also monitor if further chest pains and consider treadmill/ 1X ..."
70. At interview, the F wing officer said he heard the nurse telling the man that it was awkward at that time for her to see him, as she was about to begin issuing medication. He also heard her say that, because the pains had passed, there was no point in doing the ECG. She had added that, should the pains return later or the following day, he was to go to healthcare where an ECG would be carried out. The F wing officer said the man accepted the nurses' instructions.
71. On the way back to the wing, the man told the F wing officer that he knew that an ECG could only be carried when he had pain. He went on to say that the pains came and went quickly. The F wing officer told my investigator that the man walked back to the wing normally and not how he had walked earlier.
72. Soon after returning to the wing, the F wing officer made an entry onto the PIMS recording his dealings with the man and the nurse. He noted that he had taken him to healthcare because of chest pain, and that he had told him he should be placed on an ECG machine. The F wing officer added that, when they arrived at the treatment room, the man's pains had passed. He also noted that the nurse had said she was unable to do anything at that time as she was issuing medication. If the pain recurred, the nurse had said she should be called on her radio and that he was to be taken to the healthcare wellness room where an ECG could be carried out.

3 July

73. At 2.00am on 3 July 2008, the man pressed his in cell emergency call button. At interview the officer on night duty told my investigators that he was the one who answered the cell call. When he arrived at the cell he opened the door observation panel and spoke to the man who complained of having a headache. When asked if he had mentioned chest pain, the officer on night duty said he had not. He added that, had he done so, he would have sought advice from the night manager. Instead, he offered him two paracetamol tablets, which he accepted. The officer on night duty then went to an office where he made a note of his actions in the medications issued book (which is proper procedure at Guernsey Prison). My investigators asked the officer on night duty if he had gone into the cell. He said he had not as this was not allowed.

74. Later that morning, the man posted an application form into the healthcare applications box. (The box, which is sealed to protect patient confidentiality, is only opened by a member of healthcare staff. The applications are then taken to healthcare where they are date stamped and processed.) On the application form the man asked to see a doctor. He wrote:

“Could I see doctor Friday? Had to press the red button [this refers to the in cell emergency cell call button] Thursday 2.00am. Bad chest pain. Took Paracetamol just in case, but the pain did its usual thing and went within a couple of minutes. It lasted approx 40 min, - normally 10 min.”

75. During the day the applications box was emptied and the contents taken to healthcare. That afternoon, the nurse started duty in healthcare. At interview, she said that when she arrived she found the application form on a desk, waiting to be actioned. When asked what the purpose of applications was and the procedures, she described them as an administrative tool. The nurse said she dealt with the man’s application and wrote on the form “Appointment with [the duty doctor] – Friday, 4/7/08.”

4 July

76. On 4 July, following the man’s earlier request for him to be seen again by a doctor, he was seen by the duty doctor. At interview, the duty doctor said he had been told by the nurse that the man had been seen by the doctor the previous week. He added that the nurse had told him that his blood pressure was slightly raised, and that he had had some chest pain. The duty doctor said he had read the previous doctor’s notes in the man’s medical record, but if he wanted information from a prisoner’s own doctor he would have to telephone them.
77. The duty doctor was asked if he had seen the application form written by the man the previous day. He had not. This is contrary to what the healthcare manager told my investigators. She said his application would have been placed before the doctor along with his medical record. Both the doctor and duty doctor said at interview that, when a prisoner submits an application to see the doctor, the doctor does not normally see the application form.
78. When the man saw the duty doctor, the nurse was also present in the consultation room. At interview she said he had described his chest pain as being identical to that when he had spoken to the previous doctor. He added that the pain during the night had been “quite bad”, and that it had lasted longer than usual but then gone away again.
79. The duty doctor noted in the man’s medical record that he had reviewed him. He also referred to the entry made by the nurse the previous day. He noted that when the man had mentioned pain on the left side that he was pointing to left breast. He also noted that he had been woken during the night with chest pain lasting less than 20 minutes, and that the pain was not related to exertion, stress, emotion or breathing. The duty doctor could not explain why there was a discrepancy between his entry of “<20” minutes”, and the man’s own

application stating 40 minutes. The doctor added that he said the pain eased when he sat up.

80. As part of the medical assessment, the duty doctor noted that the man had a history of smoking. In interview, the duty doctor confirmed that he had not discussed any family history with the man. He recorded his blood pressure as 174/95, which was raised. The duty doctor also noted that examination of his heart and lungs showed they were normal, and there was no tenderness of the chest wall. The duty doctor's diagnosis was that he had hypertension and "chest pain ? cause". He told my investigators that he did not suspect that his pain was angina, as the way he indicated the site of the pain was not as he would expect from someone suffering from angina.
81. The duty doctor said the cause of the man's pain was not obvious. He had been diagnosed with high blood pressure and was a cigarette smoker, but the site and nature of the pain was not typical of heart disease. The duty doctor decided to start him on a course of Amlodipine, a drug prescribed to treat high blood pressure and angina, although – as noted – the duty doctor said he was not convinced that the pain was angina. He prescribed 5mg of Amlodipine once daily and requested a fasting blood test. (In a fasting blood test the patient has blood taken after a period of not eating or drinking certain liquids.) He added that the man should be reviewed prior to release from prison. The duty doctor said the reason for requesting a blood test was that it was a prerequisite for a treadmill test.
82. At interview, the duty doctor said that he had looked at the man's medical record, but did not recall seeing the healthcare manager health screen document. He said he would normally only read the health screen document during the reception process and not thereafter. When asked if he had read the nurses' entry on 3 July, the duty doctor said he presumed he had. However, he had not realised that the man had made an application to see a doctor.
83. My investigators asked the duty doctor whether knowing that the man's pain had lasted for 40 minutes would have made any difference to his treatment. He said he was not sure that it would. He was also asked if his decision would have changed had he seen the application. He said admission to hospital was not justified as the man looked well.
84. When asked if he was aware of the previous doctor's management plan, the duty doctor said she had not been convinced that the man had angina. He remembered that the nurse had told him that the previous doctor had requested an ECG during pain. He said the nurse had told him that there were practical difficulties obtaining an ECG during pain and that it was proving difficult for nurses to fulfil the previous doctor's instructions. The duty doctor added that the nurse had told him that, due to the prison being spread out and the time it took for nurses to set up the ECG, it was unlikely that they would manage to record an ECG during pain. The nurse had told him that not all nurses could use the ECG equipment. My investigators asked the duty doctor if he was aware of the previous doctor's instructions advising that an ambulance should be called if he had chest pain outside of nursing hours. He said he was not.

85. The duty doctor said he told the nurse that he wanted nurses to check the man's blood pressure each week. However, he did not record this instruction in his medical notes, nor did he mention it in his statement to police. Furthermore, the nurse, who had been present throughout, did not record the duty doctor's instruction onto the appointment handover sheet. The nurse wrote, "bloods next week and Amlodipine".
86. Because of the description the man had given of his chest pain, the duty doctor said he did not refer him to a specialist. He said the cardiologist in Guernsey was very busy and that access to him was slow. My investigators asked him if there was a rapid access facility on Guernsey. The duty doctor said there is a doctor who can be asked to assess cardiology problems. He added that access to a treadmill test would take approximately six weeks. He said an urgent outpatient appointment could be arranged within a few days by discussion with the duty consultant. Although he had not considered it at the time, the doctor thought it a good idea to call an ambulance if the man had pain at night.

8 July

87. On 8 July, as per the duty doctor's earlier request, the nurse took blood from the man and sent it away for analysis. The results were received on 11 July. They showed a mildly elevated cholesterol level, and a raised CRP (C reactive protein) level. The CRP is a measure of inflammation and raised CRP may be linked to coronary artery disease risk. The red blood cells were enlarged, in keeping with his history of heavy drinking. (Later, for the post mortem report, the Pathologist also analysed the blood sample that was taken on 8 July. This later test showed raised Troponin levels, indicative of heart muscle injury. It is important to note that this testing is still not available to GPs in Guernsey. It can only be requested by a specialist.)

9 July

88. On 9 July, the man made a second application to see a doctor. He wrote on the application form, "wish to see doctor, chest pains back Wed 2.00am for 40 min." Rather than placing the form in the healthcare applications box, he handed it to an officer.
89. During a discussion, the officer that took the form told my investigators that the man gave him the application form that morning. Having read the application and realising the nature of what he had written, the officer took it personally to the dispensary and handed it to a nurse. He said he had decided that the application was such that it needed to be taken direct to healthcare, rather than placed into the healthcare applications box. Although he could not remember the exact time that he took the application form, he was certain it was before 8.15am. He said the dispensary closes at 8.15am and it was still open when he arrived.

90. However, when my investigators examined the application form they saw that it had been date stamped as received into healthcare on 10 July. As with the 3 July application, there is no signature or time recorded by the member of healthcare staff receiving the form.
91. My investigators have been unable to explain the discrepancy between the application date and the date it was stamped as being received into healthcare. Unfortunately, the officer that took the form has been unable to remember to which nurse he gave it to. My investigators have looked at the nursing rota for 9 and 10 July and conclude it was either the healthcare manager or another nurse, as they were in the dispensary on the respective dates.
92. At interview, the healthcare manager said that she had picked up the application form on 10 July. She said that she had seen the man at the treatment hatch, but he had not said anything to her about chest pain. However, at a later interview with my investigators, she changed her account of events and said she did not deal with the application form and did not know who had.

11 July

93. At 12.35am, the man pressed his in cell emergency call button, and this was registered in the prison control room. The night manager went to the cell to see why the button had been pressed. The control room log shows the time that the call button was reset by the night manager to acknowledge his arrival at the cell was 12.37:57am. When he looked into the cell through the observation panel, he saw the man clutching his chest and said in interview that he looked ill.
94. Using his prison radio, the night manager asked two officers for their assistance. At interview, the night manager said he asked for the officers' assistance as there had to be three staff present when opening a cell at night.
95. The night manager told my investigators that he went into the man's cell along with one of the officers, whilst the second officer remained outside the cell. He said the man told him that he had had pain in his chest and difficulty in breathing, but the pain had eased since pressing the call button. He also said that the pain had been present about 45 minutes earlier, but that it had had gone away and then returned. He told the night manager that this was the reason for pressing the cell call button. He said he was getting repeated chest pain on a daily basis and had been keeping a note to show to the doctor in the morning. (I understand that the note is part of the police evidence file prepared for the Coroner). The night manager said the man had shown him the tablets that he was taking. He asked him if he wanted a doctor or ambulance, but the man declined the offer.
96. The second officer told my investigators that she heard the night manager ask the man if he wanted a doctor or an ambulance and that he had said he did not. He had said the pain was passing. Additionally, she remembered the manager telling him to alert staff again if the pains returned.

97. After leaving the man's cell, the night manager decided to speak to the on call duty manager, and seek his advice. The night manager told the on call duty manager what had happened and said he planned to carry out hourly observation checks on the man. The on call duty manager told the night manager to telephone the duty doctor for advice.
98. At 12.55am, the night manager telephoned the duty doctor based at an outside hospital. The call was answered by a receptionist employed by an out of hours service known locally as "Night Owl". When the receptionist asked the night manager for the man's details, he mistakenly believed that she was able to access his medical information and could see his prison medical details on her computer screen. He said the reason for presuming this was because, when she asked him for the man's name, the receptionist was able to give his home address. However, he was unaware that she only had access to her own medical records and not those of the prison, which explains why she was able to identify his home address details.
99. In her police statement, the receptionist said she advised the night manager to call an ambulance, but that he said he wanted to speak to a doctor in the first instance. At interview, the night manager said the receptionist did not advise him to call an ambulance. However, he later clarified this and said that his memory was not good enough to recall exactly what was said. He added that, had he thought the man to be in immediate danger, the correct route for obtaining medical assistance would have been via the 999 emergency services and not via the Night Owl.
100. The receptionist took the night manager's details and arranged for the duty doctor to telephone him at the prison. At interview, the night owl doctor, told my investigators that the receptionist had told him she had advised the night manager to call an ambulance. The night owl doctor added that the receptionist said the night manager had insisted on speaking to a doctor
101. In the meantime, while waiting for a doctor to telephone him, the night manager checked the PIMS. He read that the man had been taken to healthcare by the F wing officer after complaining of chest pain. (Prison officers do not have access to patient medical notes.)
102. At about 1.00am, the night owl doctor telephoned the prison and spoke to the night manager. The doctor told my investigators that the night manager said the man had experienced chest pain for about ten minutes. He added that he said he had not called an ambulance because the man had said the pain was settling. The night manager told him that the man had a heart condition and had had several similar episodes over the previous month, each lasting five to ten minutes. The doctor said he had no recollection of the night manager telling him about the PIMS entry which he had read shortly before the doctor telephoned him.
103. During the interview with the night manager, he said he could not remember if he had told the doctor about the entry made by the F wing officer on 30 June in the PIMS. He repeated that he was expecting the doctor to have the man's

medical information on his screen. At interview, the night owl doctor said he had asked the night manager if any other doctors had seen the man. He had told him that the man had been seen with similar symptoms. The doctor formed an understanding that his condition was much the same as previous and that medical follow up arrangements had been made.

104. Between them, the night owl doctor and the night manager discussed the need for the man either to be taken to hospital or to remain in the prison. The doctor concluded that, because the man's symptoms were the same as during his previous episodes, it was appropriate for him to remain in prison. He told the night manager that an ambulance should be called immediately if there were any further symptoms.
105. In making his decision, the night owl doctor was under the misapprehension that prison staff would remain with the man and any further symptoms could immediately be seen. He was unaware that he would be left alone in his cell. In interview he said that, had he known this to be the case, admission to hospital would have been appropriate to ensure adequate monitoring.
106. My investigators asked the night owl doctor whether he would have acted differently had he known of the previous doctors plans to perform an ECG during an episode of chest pain. He said that, had he been given this information, he would have arranged an immediate admission to hospital. He added that, had he known about the PIMS entry made by the F wing officer, his decision to let the man remain in prison would have changed and he would have admitted him to hospital.
107. At about 1.45am, the first officer was carrying out his security patrol duties and whilst in F wing he took the opportunity to check on the man. When he looked into his cell he saw that he was unwell. At interview, he described him as sitting slumped in his chair. The first officer said the man's head was laid back and that he was gently moving it from side to side. The first officer added that the man appeared to be alive as his head was moving. He said he was concerned about him because he looked ill and in need of professional medical treatment. He did not appear to be conscious and was, at best, semi conscious. The first officer said he did not speak to the man, and he was unaware that he was so unwell that there was a threat to his life. He said he knew he was not well, but was unable to do anything for him until the night manager authorised the cell to be unlocked. At interview, the first officer confirmed that he had not gone into the cell.
108. Using his prison radio, the first officer contacted the control room and asked for assistance. An officer colleague was in the control room and heard the first officer saying that the man did not look well and asking the night manager to go to F wing. As the radio system was on "talk through," the night manager heard the transmission and replied saying that he was on his way. Additionally, the first officer telephoned the office where he knew the night manager was located. The night manager answered the call and told the first officer that he was on his way.

109. My investigators asked the first officer if he was familiar with the “urgent message” procedure. He said he was, but that it was to be used only in an escape situation or if there was a threat to an officer. The night manager told the investigators that “urgent message” could include a medical problem.
110. At interview, the night manager said he was in the centre office when he heard the first officer’s request for assistance. He said the first officer asked him to take a look at the man, as he did not appear well. The night manager said he did not detect any urgency in the officer’s voice, nor had he used the urgent message procedure.
111. Within the same office there is a bag containing emergency medical equipment. It is intended that the bag should be taken to the patient in any medical emergency, to reduce the delay in giving treatment. The bag contains resuscitation equipment, including an automatic electronic defibrillator. (A defibrillator can restart the heart in some cases of cardiac arrest by giving an electric shock. It detects the electrical activity in the heart and gives automated instructions to the rescuer).
112. Although he knew that it was the man’s cell that he was asked to go to, the night manager did not take the emergency medical bag with him. At interview, he said he would have done so had he known the nature of the situation.
113. The officer colleague had earlier been told by the night manager that, should the man be taken ill again, then an ambulance was to be called. At interview, the officer colleague told my investigators that he did not call an ambulance because he did not know whether or not the call from the first officer was a serious matter.
114. In the meantime, whilst waiting for the night manager to arrive, the first officer decided to continue with his security patrol checks. Instead of staying with the man, he left the wing and went on to another.
115. At interview, the night manager said that, when he arrived at the man’s cell, he first of all looked into it via the observation panel. He said he saw the man lying back in a chair, with his arms by his side. The night manager unlocked the cell door and went in alone. At about the same time, the first officer returned to F wing.
116. When the night manager went into the cell he noticed that the man’s skin complexion around his neck was becoming darker in colour. The night manager said he attempted to obtain a response from the man by shouting out his name and shaking him. As he could not get a response from him, the night manager began moving him. At this point the first officer arrived and helped him move the man to the floor. (The purpose of moving him to the floor was to lay him flat on a hard surface in order to carry out cardio pulmonary resuscitation (CPR).) The night manager used his radio and called an urgent message asking the officer colleague to call an ambulance.

117. After calling for an ambulance and, knowing that the man was going to be transferred to hospital, the officer colleague began telephoning off duty prison officers. This was because he would need to be accompanied by two on duty officers which would leave the prison short of staff. The purpose of asking for extra staff to come in to the prison was to replace those escorting him to hospital.
118. Regrettably, the first two officers he telephoned both declined to attend. However, the third officer he telephoned did agree to assist and he began making his way to the prison.
119. At the time when the first officer asked for assistance, the second officer was in the control room. At interview, she said the officer colleague asked her to go straight away to F wing, although she was unaware of the nature of the call. On her way to F wing, the second officer passed the office where the emergency medical equipment was located. Unaware of why she had been asked to go to F wing, she did not collect the bag.
120. The second officer told my investigators that, when she arrived at the man's cell, she saw the night manager and the first officer moving the man to the floor. She said she handed the first officer her CPR mask. (CPR masks provide a protective barrier between the patient's mouth and the rescuer.) She said the first officer carried out mouth to mouth resuscitation whilst the night manager was carrying out chest compressions.
121. The night manager told the second officer to open the doors onto the main corridor to allow ambulance staff to enter. When she opened the corridor entrance door the ambulance had already arrived. The ambulance log notes the time of arrival at the prison gate as 1.52am, having taken approximately seven minutes to get to the prison from its starting point. It then took approximately a further seven minutes for the ambulance crew to get to the man (the main prison gates could not be overridden and had to be opened one at a time). The ambulance log shows that the ambulance crew were with the man at 2.00am. My investigators tested the gate system and found that, by not overriding the gates, there was a difference of about one and half minutes, before the ambulance could gain entry into the prison grounds.
122. By the time paramedics arrived at the man's cell, the night manager the first officer had been administering CPR for about 20 minutes. One paramedic asked the night manager to move the man from his cell into the wing association area so they could have more room to continue resuscitation efforts. In the meantime, the two prison staff were asked by paramedics to continue CPR which they did.
123. Whilst administering CPR, the paramedics attached a defibrillator to the man and administered drugs to him. The defibrillator showed that there was no shockable rhythm detected from his heart and so CPR continued.

124. On Guernsey, the paramedic service is operated by the St John Ambulance. The policy is that once CPR has started all those present have to agree to stop. Otherwise, CPR must continue. At 2.30am, as the man was not responding to CPR, paramedics asked if all present were in agreement to stop any further attempt to resuscitate him. The night manager said he wanted to try one more CPR cycle, which they did. (A CPR cycle is 30 chest compressions to two inputs of breath.) At 2.40, approximately 40 minutes after starting CPR, the decision was taken by all present to stop any further resuscitation attempt.
125. In the meantime, the on call duty manager, who had been told of the emergency, arrived at the prison. He told my investigators that the paramedics had complimented the prison staff for their attempts to resuscitate the man.
126. As no more could be done for the man, the paramedics left the prison. In line with any death in custody, the police were told of the death and arrived to begin their own investigations. Satisfied that the circumstances were not suspicious, they allowed his body to be removed from the prison. Before doing so, an on call doctor attended and confirmed that he had died.
127. Following the man's death, police officers went to the family home to break the news. As part of the police procedures, a family liaison officer was appointed to look after his family and keep them informed.
128. In the meantime, the deputy governor arranged for the staff to be de-briefed and supported. Additionally, she arranged for a critical incident de-brief to take place to allow staff to talk about what happened and obtain any necessary support. As well as caring for staff, the governor ensured that prisoners were also offered support.

ISSUES

26 June 2008

First Reception Health Screening

129. In his report, the clinical reviewer says that the healthcare manager's assessment of the man's medical history was thorough and she obtained a clear history of exertional chest pain. Additionally, the nurse undertook clinical tests and discussed the results with a doctor. The clinical reviewer says that reception health screening assessments can take a considerable time to be thoroughly completed, and it is important that the need for lengthy assessment is recognised. The healthcare manager's actions reflected good practice.

The healthcare manager's discussion with the doctor

130. My investigation has identified a disparity between the healthcare manager's recollection of her telephone conversation with the doctor and that of the doctor herself. The clinical reviewer argues that the healthcare nurse should have made a record of the conversation in the man's medical record, as it is part of his contemporaneous record of care. She did not. The clinical reviewer says that it would have been good practice for the doctor to have done the same, although he says few clinicians would routinely do so.

27 June

131. On 27 June, the doctor met the man as planned. Assisting the doctor in her surgery was the nurse. In his report the clinical reviewer states that, apart from omitting to note the character of the man's pain, or whether he had a family history of coronary heart disease, the doctor otherwise recorded a detailed history of his pain. She diagnosed atypical chest pain and considered angina as a possible cause.
132. At interview, the doctor said that the man's symptoms did not lead her to consider that a referral to a cardiologist was appropriate at that time. She said that the waiting time for a treadmill test was about six weeks. The doctor said that she believed prison nursing staff could carry out an ECG during pain, and this was partly the reason why she did not refer him, for treadmill testing.
133. In the clinical reviewer's view, given the man's age, smoking history and recent onset of chest pain, it would have been appropriate to have referred him for a treadmill test. He says it was not appropriate to delay the referral either because of the anticipated six week wait or because of the possibility that an ECG could be carried out if he presented to a nurse with pain.
134. At interview, the doctor said she thought nurses would be interacting with prisoners and that the man would have been able to alert them when he had pain. The clinical reviewer says that, in his opinion, it was unrealistic to expect that nurses would be interacting sufficiently with prisoners to allow an ECG during pain to be a realistic possibility. He concludes that the doctor's plan for

nurses to record an ECG during pain was unrealistic and that it was inappropriate to place any reliance on such an approach.

135. The doctor said that her care plan for the man was that he was to have an ECG if he had further chest pain and providing a nurse was on duty. However, if medical care was not available, he was to be taken to hospital by ambulance as an emergency patient. In her interview, the nurse said she did not hear the doctor say that the man was to be taken to hospital.
136. The clinical reviewer reports the General Medical Council (GMC) guidance on professional standards [Good Medical Practice 2006]. In its guidance the GMC states:

“In providing care you must keep clear, accurate and legible records, reporting the relevant clinical findings, the decisions made, the information given to patients, and any drugs prescribed, or other investigation or treatment.”

The clinical reviewer says that to ensure other doctors and nurses seeing the man would know of her management plan, the doctor should have made her plans clear in his medical notes.

137. It is manifest that there is disparity between what the doctor said she told the man, and the nurses' account. The clinical reviewer notes in his clinical review that, even if the doctor did advise the man to tell prison staff if he had chest pain outside nursing hours, and the officers would then call an ambulance, it was unsafe to rely on such advice. Undoubtedly, the officers have to exercise discretion when a prisoner complains of chest pain. In the clinical reviewer's opinion, in view of the specific need for action if the man developed chest pain, the Officers needed to be given specific advice on what to do if he presented with chest pain, outside nursing hours.

Medical Information Sharing (White Board)

138. Within the centre office, there is wall board which is referred to locally as the “white board”. It is used to note information of importance including medical instructions. For example, if a prisoner with a known illness is taken ill at night, instructions are written onto the white board telling staff what to do. My investigators found that no entry had been made on the board regarding the man's clinical needs.
139. As part of the investigation process, my investigators have considered the purpose of the white board. They believe it is a useful tool, but somewhat confusing and not set out in any logical order. It was difficult to determine new information and almost impossible to assess its contents at a glance. The doctor said that in her view it was the responsibility of doctors and nurses to identify healthcare issues that prison officers needed to be aware of, and that nurses should pass the information onto prison staff. In her interview, the nurse agreed that nurses should take the initiative in raising concerns. It is possible

that events might have gone differently on 11 July if not before, had officers been alerted to the man's situation through an entry on the "white board."

140. Following their first visit to the prison, my investigators brought the Governor's attention to the white board and the need for it to display information that could be readily understood. The Governor accepted this feedback. When my investigators returned to the prison to continue their investigation a few weeks later, the white board had been replaced with a well designed, purpose-built information sharing board. Information is now separated into specific sections, and clearly identifies any prisoner with a known medical condition and shows what action prison officers should take if the named person is taken ill. In addition, the PIMS now has a medical risk element as part of its database. This ensures that any member of staff accessing the PIMS can see at first glance if there is any concern relating to a prisoner's medical care.
141. The clinical reviewer says in his report that the doctor should have told the nurse to ensure prison staff knew what to do if the man experienced chest pain when nurses were not on duty. He says prison officers needed to know what the doctor's management plans were. My investigators found that the nurse did not record any details of the doctor's management plan either in the appointment/handover notes or the nurses' diary or on the white board. The nurse later accepted that she should have done so.
142. The clinical reviewer argues that the white board system should be formalised. He says the daily updating of the healthcare section of the board should be made part of the nurses' timetable. He says that it should be the nurses' responsibility to add entries to it, and warnings should be explicit about any actions that officers are expected to take.

The Governor, in partnership with the HSSD should ensure that the updating of the white board health warnings section is the sole responsibility of healthcare.

The Governor, in partnership with the HSSD, should ensure that health warnings are explicit and clearly state what actions prison staff are to take.

30 June

143. On 30 June 2008, the man had a further episode of chest pain. He told the F wing officer who took him straightaway to the healthcare treatment dispensary. When they arrived, the nurse was issuing medication to prisoners. She told the man that she was busy at that moment in time and that it was not convenient to see him. As his pain had subsided, he returned to F wing without being examined.
144. At interview, the doctor said that if the man presented to a nurse with an episode of chest pain that had just settled she would expect the nurse to log and note it, also documenting the history of chest pain. Dependent on its severity, the episode should also be brought to the attention of the on call

doctor. The doctor added that, if the pain was mild and transient and the patient felt it was no different to the pain previously experienced, it would be reasonable to wait until the next consultation with a doctor.

145. At interview, the nurse said she knew that the doctor wanted the man to have an ECG during pain. She told my investigators that she should have assessed him after completing her treatment session, and that she should have contacted the on call doctor to discuss the further chest pain and that it had not been possible to record an ECG during pain.
146. In his report, the clinical reviewer confirms that it was reasonable for the nurse to allow the man to return to F wing because the pain had settled, but that she should have assessed him after completing her treatment session. She should then have contacted the on call doctor to advise that further chest pain was occurring, and that it had not been possible to obtain an ECG during pain.
147. After returning to the wing, the F wing officer made detailed notes on PIMS about what had occurred. His notes have proved to be extremely helpful in understanding what happened when the nurse spoke to the man, and are a good example of the importance of recording information. I regard the F wing officer's actions in recording his contact with the man as an example of good practice. Although I make no formal recommendation, the Governor may wish to share my comments him and his manager.

Medical Applications

148. On 3 July at 2.00am, the man pressed his in cell emergency call button. The officer on night duty answered the cell call. He said the man had complained to him of having a headache, and so he gave him two paracetamol tablets. He said the man did not mention chest pain. Although I make no criticism of the officer, his account of events does not appear to agree with what the man wrote in his application form.
149. The clinical reviewer says in his report that the procedure for administration, recording and monitoring of paracetamol given outside nursing hours is good practice.
150. The application form was received by the nurse. Although it was date stamped, the nurse did not initial it, nor add the time of receipt. She made an entry in the man's medical record, noting the date of the application and that he had complained of chest pain. She told my investigators that she did not discuss the reported chest pain with anyone.
151. At a later interview, the nurse said she should have acted on the information given by the man, and that she should have assessed him. She also said that she should have discussed his symptoms with a doctor, rather than simply booking an appointment for the following day.

152. At interview, the doctor said that she was not made aware of the increase in the man's chest pain. Had she been aware of a 40 minute episode of chest pain during the night, she would have expected the man to have been admitted to hospital for further investigation.
153. Six days later, on 9 July, the man submitted a further application form. Although we do not know which member of healthcare staff received his application, it is clear from healthcare records that nothing was done with it other than adding a date stamp. There is no evidence on PIMS of any action being taken by healthcare staff to make an appointment. There is no evidence of an appointment being made on the appointment handover sheet for the next doctor's clinic which would have been the following day. There is no evidence that anyone went to assess his condition.
154. At interview, the duty doctor told my investigators that his expectation of nursing staff receiving such an application would be that a nurse would visit the patient, make a general assessment, check pulse, blood pressure, and perform an ECG if possible. He would expect a nurse almost certainly to call a doctor. The duty doctor went on to say that he would expect a Registered General Nurse to recognise that a 40 minute episode of night time chest pain in a man of this age is a significant event, and a possible indication of a heart attack.
155. In his report, the clinical reviewer says it was commendable that the officer that took the man's application form took account, and responded by handing it directly to a nurse. However, it is a matter of great concern that healthcare staff did not react to the second report of 40 minute chest pain or take any action. Nurses should have assessed the man, undertaken an ECG, and contacted a doctor. The clinical reviewer says the history should have raised the possibility of unstable angina in the mind of a doctor, and thereby prompted urgent admission to hospital.

11 July

156. The clinical reviewer suggests it is arguable whether or not the night owl doctor put himself in a position to make an adequate assessment of the man. It could be argued that the case of a man at this age with chest pains in the night should always prompt admission for assessment to exclude unstable angina. However, it is clear that the night owl doctor took care to establish that the pain had gone within five or ten minutes, and that it was the same in this respect as previous episodes. The clinical reviewer says the night owl doctor considered angina as a possible diagnosis, but he did not have a high suspicion of cardiac disease because of the way the man was being managed by prison doctors. The night owl doctor established that the man had been seen by a prison doctor in the previous week when it was felt unnecessary to do an ECG or arrange urgent secondary care. He mistakenly believed that the man would be watched by prison officers.
157. In the opinion of the clinical reviewer, the night owl doctor acted reasonably and appropriately with the information available to him. Unfortunately, he did not have the full information available to him. In considering this, I note that the

night manager apparently did not inform him of the PIMS entry and this was because he was under the misapprehension that the doctor had access to it. However, the night manager did tell the night owl doctor of his knowledge of the man's history of chest pain whilst in custody. It is worth noting that the night manager did not have access to the man's medical record and as I have already stated, there was no medical information on the white board. The clinical reviewer comments that if the doctor had more information about the man's condition and need for an ECG he would have arranged urgent admission to hospital. Although I make no formal recommendation, the Governor might wish to ensure that operational staff are aware that PIMS and medical records cannot be seen by out-of-hours medical staff.

Urgent Message Procedure

158. It is clear from my investigation that it was not immediately known to prison staff what the situation was on 11 July when the man was found collapsed. Although, available, the emergency grab bag was not taken to his cell because prison staff did not know what the problem was.

The Governor should ensure that prison staff are aware of the correct radio procedure for raising an urgent message.

Entering a cell at night

159. My investigators found that uniformed staff at all grades did not understand the routine for entering a cell at night, and that a number were unaware of revised local instructions updated in March 2008. My investigator raised this and the first officer's actions as an immediate urgent finding.

160. In his feedback letter of December 2008, my investigator said:

“It was clear from the uniformed staff interviewed, and a number who we spoke to on an ad hoc basis, that they believed a cell could not be unlocked at night, without a minimum of three officers being present. This is an important factor in [the man's] case, as clearly he appears to have been alive when the night patrol officer looked into his cell and realised that something was wrong. Despite knowing that [he] had been taken ill a little earlier, he chose not to enter the cell, but did raise the alarm. He then left [the man] and continued with his pegging duties, in the mistaken belief that he could not go in.

“As I am sure you will appreciate, this will be a difficult finding for [the man's] family to comprehend. Once we were aware of what had occurred I raised this as an urgent finding and an issue requiring immediate action.”

161. The clinical reviewer says in his report review that, given his description of the man's appearance, it is difficult to understand why the first officer left him to continue with his security patrol. I have to agree.

The Governor should remind staff on the correct procedure for entering a cell at night.

162. In her letter of 2 February 2009, the deputy governor said that every member of operational staff had been issued with an individual copy of the procedure for unlocking a cell during the night when there is a potential or actual threat to safety. Additionally, she said that my investigator's finding had formed a significant part of a full staff briefing which had taken place in October 2008 and that revised night instructions were issued on 16 November. A new notice to staff had been issued reminding all staff of the correct radio procedures and what to do in the event of an urgent message.

Resuscitation Attempts

163. Prison officers are not often given public recognition for the work they do. They deal on a daily basis with sometimes difficult and dangerous people, but are expected to show a caring attitude towards those in their charge. The man's circumstances are a good example of what officers do in trying to care for prisoners.
164. By the time the St John Ambulance staff arrived at the man's cell, prison staff had been administering CPR for anything up to 20 minutes. Whilst the ambulance staff set up their emergency equipment, they asked prison staff to continue with CPR which they did without question. After carrying out their own checks, and almost 40 minutes from when CPR first started, ambulance staff asked all present if they were in agreement to stop. The night manager asked to carry out one further round of CPR, which they did, but unfortunately without success. I am satisfied that once it was known he had collapsed, prison staff did everything possible to rescue the man.
165. Given the fact that prison staff had attempted resuscitation for so long and must have been extremely tired, their efforts to revive the man are worthy of public commendation. Although I make no formal recommendation, the Governor will wish to share my comments with those involved.

Communication/Prison Instructions

166. The events of 11 July highlight the issue of communication and the need for officers to take individual responsibility in keeping up to date with local instructions and policies. It was evident to my investigator that some officers and uniformed managers were not routinely using the prison intranet. This was fed back to the Governor.
167. Following his feedback, my investigator followed the matter up in writing. In his letter dated 9 December 2008, my investigator wrote:

"We found evidence that although staff knew where information is held, they did not access it on a regular basis. As an example, none of the uniformed staff we spoke to knew that your instructions for entering a cell at night (GPI 2.77) had been updated on 19 March 2008."

The Governor should remind all staff of their responsibility to ensure they are up to date with local instructions and know how to access information.

Emergency access into the prison at night

168. The gate area is fitted with an override system, enabling both vehicle gates to open at the same time. However, the facility is only available during daytime hours. At night time when staffing levels are at the minimum level, the override system, although still available, is not used because of insufficient staff being on duty to cover the security risk of both gates being open at once.
169. In this man's case, the emergency ambulance crew were unable to gain access into the prison as quickly as they would have done during the day as gates could not be overridden. Once in the prison grounds, further delay occurred whilst the inner security fence gate was opened and closed manually, and then the main corridor unlocked to allow the emergency crew to proceed to the wing. My investigator raised the delay as an urgent finding.
170. In her letter dated 2 February 2009, the deputy governor said that the night procedures had been reviewed and updated instructions introduced on 16 November 2008. She said that all senior officers and night teams have completed refresher training in gate control. She added that all night gate staff were aware of the gate override system and familiar in its use. Additionally, with the assistance of the local fire brigade, the override system had been tested during the day on 4 November with no delays. However, the deputy governor's letter does not make it clear whether the override system was tested under the same conditions as would be in place during the night. She added that the routine for operating the override system will form a regular part of testing the prison contingency plans.

The Governor should ensure that the testing of override systems replicates night time staffing levels and routines.

Doctor's attendance

171. The current level of doctor cover at the prison is Monday, Wednesday and Friday. My investigators have been told that in Guernsey, someone wishing to see a doctor on the day they ring can expect to be seen that day. Their level of access to a doctor is arguably better than in those in the prison, albeit the prison nurses can call a doctor in if they are concerned. There is the opportunity for nurses to ask a doctor to attend if necessary, but it would appear that this is done rarely. The nurses are expected to triage the patients in the prison. They did not have triage algorithms despite a previous HMCIP recommendation to do so.

The Governor in partnership with the Healthcare Group should consider increasing the frequency of doctor attendance to every weekday and include Saturdays.

Staff/prisoner relationships

172. I have been pleased to learn from my investigator about the positive relationship between staff and prisoners. He said there was noticeable interaction and clear evidence of staff taking the time to speak to prisoners, even if simply to say hello. He reported the atmosphere as relaxed, and that it made for a pleasant feel about the prison. I invite the Governor to share my comments with his staff.

THE CLINICAL REVIEWER'S CONCLUSIONS AND RECOMMENDATIONS

173. In the report obtained by the Health and Social Services Department (HSSD), the first clinical reviewer concluded that "It is my opinion, the medical care and advice he received in prison and from the hospital were of a high standard and appropriate. From the facts available to me, I do not consider that his imprisonment, or the medical care he received contributed materially to his premature death."

174. On behalf of Her Majesty's Comptroller, a MD FRCP FACC Consultant Cardiologist, was asked to prepare a supplementary expert medical report regarding the man's death. His report was completed on 6 November 2008. In his report the clinical reviewer notes that the consultant cardiologist states that:

"... in view of the combination of the documented medical history and the computer interpreted ECG findings, a presumptive diagnosis of an acute coronary syndrome could not have reasonably been made. Had it been, I would have expected that this would have triggered admission to hospital.

There was no further opportunity for medical staff review prior to the patient suffering the acute ischaemic event on 11 July 2008.

In summary, although the patient did suffer an acute coronary syndrome proven subsequently at Post Mortem, this could not have been reasonably recognised from the medical information available at the time from the expertise of the medical staff and without a clinical diagnosis of an acute coronary syndrome, it would not have been expected that the patient would have been admitted to hospital as an emergency admission at the time of either medical review."

He adds that:

"...if the acute coronary syndrome had been recognised and the patient admitted to hospital, it is highly likely that the outcome would have been different and there would have been an expectation of a good outcome from medical therapy, combined with either subsequent percutaneous coronary intervention or coronary bypass surgery"

175. The clinical reviewer has taken into account the expert cardiological opinion of the consultant cardiologist, and agrees with him that a presumptive diagnosis of an acute coronary syndrome could not reasonably have been made. However, the clinical reviewer has approached this investigation and his clinical review from the perspective of a clinician working in general practice or in primary medical care. This means forming a judgement about what a doctor in general practice should reasonably be expected to consider. He has addressed the question of whether there were occasions when the man's presentation should have led to him being referred or admitted to hospital. In the clinical reviewer's opinion, there had been a number of occasions when the man's symptoms ought to have raised sufficient concern for further action to have been taken.

176. The clinical reviewer comments that, notwithstanding the consultant cardiologist's expert opinion, it is his opinion that there were sufficient grounds for concern to expect that referral to a cardiologist should have been made on 27 June, and the man's presentation on 4 July indicated the need for admission to hospital or urgent referral. Nurses should have responded on 30 June, 3 July and 10 July by discussing his symptoms with the duty doctor. Had they done so, a referral for treadmill testing would have been the appropriate response to the episode of chest pain on 30 June. The clinical reviewer goes on to say that urgent admission to hospital was the appropriate response to the two episodes of 40 minutes of chest pains, described in each of the applications made on 3 and 9 July.
177. The clinical reviewer argues that had a referral been made, and the discipline officers made aware that an ambulance should be called if the man had chest pain outside nursing hours, it is likely that the night manager would have arranged admission when the man first pressed his cell call button on 11 July. Additionally, the clinical reviewer is satisfied that the out-of-hours doctor would almost certainly have arranged hospital admission for him, had he known about the management plan. In the opinion of the clinical reviewer, it is possible that the outcome on the night of 11 July would have been better had admission to hospital occurred before the man had his heart attack and cardiac arrest.
178. The clinical reviewer says the investigation has found significant deficiencies in communication within the healthcare department, within the discipline staff of the prison, and also between these two professional groups. He adds that clinical decisions, and systemic and individual communication deficiencies, are relevant in assessing the care that the man received.
179. In addition to the recommendations already identified, the clinical reviewer makes the following additional recommendations, which I support:
- The HSSD should undertake a review of the use of the Appointments/Handover sheets, and any necessary training should be given, to ensure good communication between members of the healthcare team based in the prison.
 - The HSSD should undertake a review, and any necessary training should be given, of the procedures for nursing staff to raise healthcare warnings about patients/prisoners to discipline staff. This should include, but not be limited to, the morning management meetings.
 - The Governor, in partnership with HSSD, should consider delivering appropriate training in the recognition and response to medical emergencies, including some of the indications for an immediate ambulance call.
 - The HSSD should ensure that Triage Algorithms are obtained and used by all nurses to ensure consistency and best management. (Repeat recommendation from the Chief Inspector of Prisons' Report 2005. Triage

Algorithms are a decision making tool used by nurses to assess and determine the best route to keep a patient safe.)

- The Governor, in partnership with the HSSD, should consider redesigning the reception health screening document to include the question: “Is there a need to raise a health warning with discipline staff?” This should follow through to the healthcare section of the wing and cell allocation risk assessment form.
- The Governor, in partnership with the HSSD, should redesign the medical application and request forms for healthcare, so that the date and time of receipt and the name of member of staff receiving the form can be recorded.
- The Governor, in partnership with the HSSD, should ensure that all entries in the prisoner medical record are dated and timed, in accordance with NMC (Nursing and Midwifery Council) standards.
- The Governor, in partnership with the HSSD, should ensure that medical applications or request forms are made available to the doctor during consultations with the applicant prisoner.
- The Governor, in partnership with Healthcare Group, should ensure that a contract or Service Level Agreement for GP services is completed.

RESPONSE BY THE HEALTH AND SOCIAL SERVICES DEPARTMENT (HSSD) TO FEEDBACK

180. As a result of feedback given during the course of my investigation, a member of the HSSD has implemented a Performance Management Plan setting out the following objectives to the nursing team in prison healthcare. The plan has been fully endorsed by the clinical reviewer:
- To involve the Clinical Nurse Specialist with responsibility for cardiac rehabilitation with the aim of providing cardiac awareness training sessions for the Prison Healthcare Team. Target date January 2009.
 - To introduce a service user information leaflet specifically for prisoners in relation to the management of chest pain. This will involve making minor adjustments to HSSD leaflet 391 so that it reflects the security measures required within a prison setting. Target date January 2009.
 - To bridge the theory practice gap by attending accredited training/updates in the following areas:
 - ECG up-date workshop
 - Acute medical emergencies
 - All staff to attend during 2009.
 - To invite the Royal College of Nursing to review Prison Healthcare service delivery as part of a wider prison service review. This has been agreed to take place in February 2009.

CONCLUSION

181. I have considered carefully the workings of Guernsey Prison. I am conscious of the dangers of unthinkingly applying a direct comparison with what is required in England and Wales. Having said that, it would be quite wrong were I not to expect Guernsey Prison to treat prisoners decently and properly.
182. My investigator found aspects of the prison that on the mainland would be considered old fashioned. Because they have always done things in the same way, some staff were unaware of changes in procedure and did not know what would now be expected of them. I am aware that the deputy governor has identified a number of issues since her arrival in Guernsey, and is driving forward the necessary changes. However, it would appear that some staff may be resistant to change.
183. As an example of outdated practices, although not connected to the man's death, my investigator noted that all staff on duty at night carried security keys and some could not see a reason not to do so. This is not a practice that would be acceptable to HM Prison Service in England and Wales and is something the deputy governor has now addressed. On the other hand, the PIMS system is far superior to what is used in prisons on the mainland. PIMS is informative and well used.
184. I am satisfied that when the man first arrived into prison he was assessed correctly by the reception nurse. His medical history was obtained, with the result that an ECG was carried out which noted a problem with his heart.
185. However, from then on there were aspects of the man's medical care that could not be regarded as satisfactory. There were deficiencies in the recording of the doctor's management plans. There was insufficient account and action taken in response to the reporting of prolonged night time chest pain. From the consultant cardiologist's report, and the clinical reviewer's report, it is quite clear that if admission to hospital had occurred before 10 July 2008 it is highly likely that the outcome would have been different. In the clinical reviewer's opinion, "it is possible that the outcome on the night of 11 July would have been better had admission to hospital occurred before the man had his heart attack and cardiac arrest."
186. I have also considered carefully the first officer's actions in leaving the man when clearly ill, and continuing with other duties in the mistaken belief that he could not enter the cell. His actions reinforce my view that some staff may rely far too much on how things have always been done rather than keeping up with new practices and procedures. What the outcome might have been had the first officer gone into the cell cannot be known, but I find his conduct very difficult to understand.
187. Once it was realised that the man had collapsed, prison staff did everything possible to resuscitate him. CPR continued for a considerable time. Even when the opportunity came to stop, the night manager wanted to try one more

time to rescue the man. I am satisfied that the resuscitation attempts were appropriate; indeed, that they were admirable.

RECOMMENDATIONS

1. The Governor should remind all staff of their responsibility to ensure they are up to date with local instructions and know how to access information.
2. The Governor should remind staff on the correct procedure for entering a cell at night.
3. The Governor should ensure that the testing of override systems replicates night time staffing levels and routines.
4. The Governor, in partnership with the HSSD, should ensure that the updating of the white board section relating to healthcare is the sole responsibility of healthcare.
5. The Governor, in partnership with the HSSD, should ensure that health warnings are explicit and clearly state what actions prison staff are to take.
6. The Governor, in partnership with Healthcare Group, should consider increasing the frequency of doctor attendance to every weekday and include Saturdays.
7. The Governor should ensure that prison staff are aware of the correct radio procedure for raising an urgent message.
8. The HSSD should undertake a review the use of the Appointments/Handover sheets, and any necessary training should be given, to ensure good communication between members of the healthcare team based in the prison.
9. The HSSD should undertake a review, and any necessary training should be given, of the procedures for healthcare professionals to raise healthcare warnings about patients/prisoners to discipline staff. This should include, but not be limited to, the morning management meetings.
10. The Governor, in partnership with HSSD, should consider delivering appropriate training in the recognition and response to medical emergencies, including some of the indications for an immediate ambulance call.
11. The HSSD should ensure that Triage Algorithms are obtained and used by all nurses to ensure consistency and best management.
12. The Governor, in partnership with the HSSD, should consider redesigning the reception health screening document to include the question: "Is there a need to raise a health warning with discipline staff?" This should follow through to the healthcare section of the wing and cell allocation risk assessment form.
13. The Governor, in partnership with the HSSD, should redesign the medical application and request forms for healthcare, so that the date and time of receipt and the name of member of staff receiving the form can be recorded.

14. The Governor, in partnership with the HSSD, should ensure that all entries in the prisoner medical record are dated and timed, in accordance with NMC (Nursing and Midwifery Council) standards.
15. The Governor, in partnership with the HSSD, should ensure that medical applications or request forms are made available to the doctor during consultations with the applicant prisoner.
16. The Governor, in partnership with the Healthcare Group, should ensure that a contract or SLA for doctor's services is completed.

GOOD PRACTICE

1. The reception health screen carried by the healthcare manager was very thorough. The recording of an ECG and contacting the doctor was good practice.
2. The clinical reviewer says in his report that the procedure for administration, recording and monitoring of Paracetamol given outside nursing hours is good practice.
3. The F wing officer's action in recording in the PIMS his contact with the man was good practice.