

**Investigation into the circumstances surrounding the
death of a man in July 2009,
at HMP The Verne**

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

January 2010

This is the report of an investigation into the death of a man in July 2009. The man collapsed in his friend's room at about 11.15pm on 13 July 2009. His friend alerted the night officer who radioed for assistance. Within a few minutes officers arrived and an emergency ambulance was called. Two officers attempted cardio pulmonary resuscitation (CPR) until the arrival of paramedics at 11.23pm. The man was confirmed dead at 00.17am by the paramedic. He was 58 years old.

The man did not have any next of kin recorded in his prison file and his friends confirmed that he did not have any contact with family or friends whilst in prison. I extend my condolences to his friends at The Verne and those who have been touched by his death.

HM Coroner for Western District in Dorset was informed of the Ombudsman's investigation. A post mortem was undertaken which found that the man died of a heart attack caused by coronary artery thrombosis (a clot in a heart artery).

The investigation was undertaken by one of my colleagues. A review of the man's healthcare whilst in custody, was commissioned from Dorset Primary Care Trust (PCT). I am grateful to a doctor for his report. I would also like to thank the Governor of The Verne and her staff for their help and assistance. I am especially grateful to the liaison officer.

I make one recommendation to the Governor in training night staff in the use of defibrillators (machines used to restart the heart). I acknowledge the good response by prison staff to the man collapse and the support offered to the man's friends. Additionally, I note the good practice of staff in following up that support to prisoners on the wing. I make one observation regarding the endorsement in prison files of prisoners who decline to provide their next of kin details to be recorded. Finally, I note three areas identified by the clinical review for the attention of the Head of Healthcare.

In this final report the Governor has partially accepted the recommendation and accepted the three areas of good practice as noted in the draft report.

Jane Webb
Deputy Prisons and Probation Ombudsman

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SUMMARY

The man was remanded to HMP Wormwood Scrubs in January 2006 charged with drug importation. He was sentenced to eight years imprisonment on 31 March and returned to the prison. The man transferred to The Verne on 15 January 2007.

On his reception into The Verne, clinical staff noted that the man had a history of angina, asthma, high blood pressure and depression. It was further noted that he had enlarged breasts following hormone therapy in the 1990s. The man was prescribed medication for his illnesses and placed on a wing.

Over the next two years, the man regularly attended the healthcare unit for blood pressure checks and support for his depression. In September 2007, with the support of the doctor, an application for funding was made to Dorset PCT for plastic surgery to reduce his breast tissue. In 2008 Dorset PCT told the doctor they could not fund the operation.

Regular reviews of the man's blood pressure were conducted, and were variable, but often high. Following blood tests for high cholesterol medication was prescribed. In May 2009, the man was seen in the healthcare unit with a swollen testicle. An appointment was made for him to see a specialist. The man was admitted to hospital on 26 May. His testicle had doubled in size and he was in pain. He was discharged back to The Verne four days later, but readmitted overnight on 30 June as the problem was not improving. A surgical procedure to remove a cyst was planned for a future date.

On 13 July, about 11.00pm, the man was having coffee in a friend's cell when he collapsed onto the bed. The friend immediately alerted night staff and four officers attended. Three of the officers carried out CPR whilst an emergency ambulance was called. At 11.24pm, a paramedic attended to the man and CPR was continued by prison staff. Further ambulance personnel arrived and, despite intensive medical care, the man was pronounced dead at 00.17am by the paramedic.

I note the three areas of suggestion by the clinical reviewer in relation to healthcare issues for consideration by the Head of Healthcare. One recommendation is for the attention of the Governor relating to training prison night staff in the use of defibrillators. I acknowledge the good practice of staff who responded to the man's collapse and the support given to prisoners following the death of their friend. Lastly I make one observation about recording next of kin details.

THE INVESTIGATION PROCESS

1. The investigation into the man's death was opened on 23 July 2009, when my colleague visited The Verne. She was met by the liaison officers and reviewed the man's prison and medical files. Copies of documents from those files were given to my colleague. She met the Governor and explained the process of the investigation. The Ombudsman's terms of reference and notices of investigations had been sent to the prison in advance of her visit.
2. Later, my colleague visited C wing and spoke to two prisoners who knew the man. One of the prisoners was present when he collapsed on 13 July. My colleague also spoke to the Chair of the Prison Officer's Association, Officer. The Chair of the Independent Monitoring Board, had already apologised to Ms Gilbert that he would not be available to see her. Before my colleague left The Verne, she spoke to a counsellor who regularly saw the man.
3. A review of the man's healthcare whilst at The Verne was commissioned with Dorset PCT. On 1 October, my colleague spoke to the senior nurse in the healthcare unit.
4. The man did not offer any next of kin details to be recorded in his prison records, therefore it has not been possible to identify any family or friends to be involved in this investigation.

HMP THE VERNE

5. The Verne is a category C training prison for up to 595 male adult prisoners. There are six identical wings which include dormitory accommodation with curtained bed spaces. A1 and C1 wings accommodates prisoners who have attained the highest level in the Incentives and Earned Privileges scheme. (The IEP scheme is a reward system for prisoners who adhere to prison regime and participate in work, education and offending behaviour programmes.) Those wings allow the prisoners to have own keys to their rooms. Prisoners are not locked into their rooms and there is a certain amount of freedom to move around the wing. However the prisoners must be in their rooms for roll checks.
6. Health services at The Verne are commissioned and provided by the Dorset Primary Care Trust. The healthcare centre is a single storey building located at one end of the prison. There are no inpatient facilities and healthcare staff are not on duty, in the prison, during the night. Prisoners who need inpatient care are normally taken to the County Hospital in Dorchester, some 14 miles away.
7. The Verne was last inspected by HM Chief Inspector of Prisons in August 2007. An extract from the summary of that report said:

“The healthcare department provided a good range of clinical services. There was a range of nurse-led clinics, and an identified nurse for older prisoners. There were good dental services, although the waiting list was long. Mental health services were good, with dedicated primary care nurses holding daily clinics. There were good relationships with the local primary care trust, and opportunities for staff to work in the community to maintain skills and knowledge of current practice. Many NHS outpatient appointments were cancelled because of difficulties with staffing escorts.” (In this final report, Dorset Community Health Service commented that staffing escorts refers to prison officer escort, not healthcare staff.)
8. In their report on The Verne for the period November 2006 - May 2008, the prison’s Independent Monitoring Board (IMB) also drew attention to some aspects of the provision of healthcare by the Dorset Primary Care Trust. (IMB members are volunteers who impartially monitor the prison and prisoners.)
9. The Ombudsman has investigated three other natural cause deaths at The Verne. In my report into one of those deaths, attention was drawn to the absence of defibrillators and recommended that the Primary Care Trust should provide a defibrillator for use in the establishment. I will deal with this in this issue section of the report. A previous death at The Verne was similar to that of the man in that he also had died of a heart attack. However, that death occurred during the day when healthcare staff were on duty.

KEY FINDINGS

10. The man was received into The Verne on 15 January 2007. It was noted in his first reception health screen that he had high blood pressure and angina for which he was prescribed a Glyceryl Trinitrate (GTN) aerosol spray. The man told the nurse he experienced mild depression when 'things go wrong'.
11. A doctor examined the man the following day and noted that he had been prescribed an anti depressant for two years to help stabilise his moods. The doctor further wrote that the man had angina, asthma since childhood and gynaecomastia (enlargement of breast tissue). The doctor concluded his examination by recording that the man had considered gender realignment but had stopped the full process following the death of his partner. A medication regime was prescribed for the man, which included Atenolol, the GTN aerosol spray and aspirin for angina, Citalopram for mild depression and an inhaler for asthma.
12. On 23 January, the doctor referred the man to an ophthalmology department out patient appointment at hospital following a suspected diagnosis of glaucoma at an optician's examination. Three weeks later, the man was seen by a nurse. The nurse noted that the man had reduced the amount he smoked but refused nicotine replacement therapy. He told the nurse that he had not settled at the The Verne and had experienced several angina pains since his transfer. The nurse arranged a blood test and to repeat his blood pressure readings one week later.
13. The man saw the doctor on 14 March. He told the doctor he was not sleeping and worried about sharing a cell with another prisoner. The doctor offered advice on smoking cessation and prescribed Simvastatin, for high cholesterol. In April it was noted that the man failed to attend smoking cessation sessions. On 27 April, The man's blood pressure was reviewed and found to be within normal range (a normal range of blood pressure is 130/80).
14. A week later the man told the doctor that he was, 'going through hell', in this prison because of his sexuality and was being harassed and wanted a single cell. The doctor advised the man to speak to his personal officer as this was a discipline matter. (It is unknown if the man spoke to his personal officer, however he was given a single cell when he moved onto C1 wing in May.)
15. On 18 September, a nurse checked the man's blood pressure which remained within normal range. A month later, he discussed with another nurse his concerns about his breasts. He felt that prisoners were making fun of him which he found tiring and upsetting. The nurse agreed to speak to the doctor and a registered mental health nurse. The doctor saw the man on 16 October, when they spoke about his enlarged breasts. The doctor wrote that the man had not been taking hormone therapy for four to five years and his breast tissue had not reduced. The doctor agreed to refer the man to a plastic surgeon.

16. A nurse saw the man on 22 October and he again mentioned the difficulties he was having with other prisoners. He had no thought of harming himself but had difficulty sleeping which was affecting his motivation. The man told the nurse that he was now waiting for an appointment for the removal of his breasts. The nurse told him she could see him again in two weeks if he needed support.
17. On 14 November, the doctor received a letter from the out patient manager of a hospital. The letter indicated that funding was not routinely provided for breast surgery and application for funding would need to be secured through the Primary Care Trust. The hospital would consider the referral once funding was secured.
18. The man was seen by a nurse on 23 January 2008. He was generally unwell, complaining of chest pain, heartburn and his fingers were white with pins and needles sensations. The man told the nurse he had used his GTN spray several times and his inhaler for his asthma over the previous three days. The nurse discussed the man's symptoms with the doctor who then prescribed Omeprazole for indigestion, and said he would review him again in one week's time.
19. The following week, the doctor examined the man and wrote that he was feeling better since taking Omeprazole. The doctor told the man that an application had been made to the PCT for funding his breast surgery and he was waiting for a response. On 1 April, a nurse reviewed the man's general health and noted that his blood pressure was in normal range.
20. Two days later, in response to the PCT's request for additional information, the doctor wrote to the senior commissioning manager. The doctor gave a medical history of the man's general health and his hormone treatment in the 1990s. The doctor wrote that the man's breasts were noticeable and causing him great embarrassment. In conclusion the doctor said that the man had told him that he had been listed for surgery in London prior to his arrest.
21. On 25 April, the PCT wrote to the man and the doctor to inform them that his application for breast surgery had been rejected. Three days later, the man was seen by a nurse who noted his poor emotional state. He was upset about his medication and the news that his funding for breast reduction surgery had been rejected. The man felt he should not be prescribed dispersible aspirin and said he had been bleeding from his rectum over the last two days. The man preferred to take aspirin in tablet form.
22. The following day, the man was seen by the doctor who examined his rectum and abdomen. He told the doctor that he had little energy and complained about taking aspirin. The doctor asked for blood samples and told the man to report any heavier bleeding. On 29 April, the doctor referred the man for an out patient appointment with a colorectal (bowel) surgeon.

23. The man saw a nurse on 23 June and told the nurse he was still getting some occasional chest pain and shortness of breath whilst walking. His blood pressure was high at 185/114. A week later, the nurse re-checked his blood pressure which had improved but was still high at 173/96. The man told the nurse that he had asked for a transfer from The Verne which would be beneficial for him. The nurse arranged to check his blood pressure in two weeks' time.
24. The man declined to attend hospital for a sigmoidoscopy on 11 July. (A sigmoidoscopy examines the bowel through a camera passed into the rectum.) A nurse advised him to go to the appointment to check the symptoms of his rectal bleeding. However, the man said he did not want to go, he felt better and the medication had resolved the bleeding. He signed a disclaimer form declining the procedure and attending the hospital. The man told the nurse that he was still finding it difficult to settle at The Verne. The nurse advised the man that she would speak to the doctor about his work in the gardens which he found too strenuous.
25. On 17 July, a nurse checked the man's blood pressure, which had risen to 171/121. He told the nurse that he had chest pain the previous evening and used his GTN spray. The nurse said that the man should only work on light duties and she would inform the allocations officer of this. (An allocation's officer arranges work placements within the prison.) The doctor prescribed Amlodipine, a medication for high blood pressure.
26. Three weeks later, the man's blood pressure reading was noted to be 168/92 which had improved since he had started the Amlodipine. On 28 August, a greatly improved reading of 143/85 was recorded. The man was also noted to be happier working with the fish ponds, watching television and making friends. The man had a blood test on 25 September and a month later his prescription of Simvastatin was increased as his cholesterol levels had risen.
27. The man saw the doctor on 4 November and his blood pressure had risen to 180/106. He told the doctor that he had reduced his smoking and felt his angina was well controlled. Six weeks later, the doctor again noted that the man's angina was improving and his blood pressure, whilst above normal range, was recorded at 169/91.
28. On 20 January 2009, the man had a blood test, which showed improved results. A month later, the man saw a nurse who noted that his blood pressure reading was high at 194/94. He told the nurse that his blood pressure had been up and down for years. The man said he needed a heart bypass operation but would not be allowed to have one as he refused to give up smoking.
29. A doctor saw the man on 9 March. He told the doctor that although the PCT refusal to fund his breast surgery still concerned him he had no thoughts of self harm. The doctor increased his medication for depression and noted that his blood pressure was high at 224/109. On 1 April, a blood pressure check showed that the man's reading had improved at 175/91, but still above normal

range. Two weeks later another improved blood pressure reading was recorded at 166/87.

30. The man saw the doctor on 11 May, he had pain in his testicle and on examination, the doctor thought he could feel a cyst. A referral for the man was made to hospital .
31. Between 13 May and 26 May, The man was seen three times by nurses and a doctor complaining of pain and swelling in his scrotal area. Medication was prescribed but the man was admitted to hospital on 26 May as his testicle had swollen to double the normal size and he was in pain. The man was escorted by two officers and restrained by an escort chain. (An escort chain is a 1.8 metre length of chain with one cuff attached to an officer and the other cuff to the prisoner.) He was discharged back to The Verne on 30 May, and a cyst was diagnosed in his scrotum. Antibiotic medication was prescribed. An out patient appointment would follow, when a surgical procedure would be considered.
32. On 1 June, the man was prescribed with medication to help him sleep. Three days later, he saw the doctor who noted that, whilst his testicle was still swollen his symptoms were improving. A fortnight afterwards on 15 June, the doctor discussed the man' condition with the urologist as the swelling was increasing. Two weeks later, the man was given a sick note by the doctor to excuse him from his work duties.
33. The man was re-admitted to hospital on 30 June. The swelling to his testicle was still present and worsening. He was again escorted by two officers and restrained on an escort chain. An ultrasound procedure (a scan using high sound waves) confirmed that the man had a cyst. Antibiotic medication was prescribed and arrangements made for a surgical removal of the cyst. The man returned to The Verne the following day.
34. On 7 July, a doctor reviewed the man and noted that the swelling in his scrotum was not improving. The doctor recorded that the swelling was worsening and he prescribed Promethazine Hydrochloride (an antihistamine). The doctor made contact with the urologist to ask for the surgical procedure to be expedited.
35. At about 10.00pm on 13 July, the man went to see a friend for coffee. (The regime on C1 wing allows prisoners to have their own rooms with keys and freedom to move around the wing.) This was a usual habit for the two friends. The man sat in chair and after an hour, his friend thought that he looked unwell. Suddenly he seemed to fall from the chair and across the friend's bed. The friend saw urine on the floor and was unable to rouse the man. The time was now 11.10pm.
36. The man's friend immediately left his room and ran to the wing office on the ground floor. He told an Operational Support Grade (OSG) that the man had collapsed in his room. The OSG ran upstairs to the man's friend's room and saw him lying on the bed. The OSG made an urgent radio call for

assistance. Shortly afterwards, the Night Orderly Officer (NOO), a Senior Officer (SO) and another officer responded and arrived in the man's friend's room. The officers moved the man to the floor, into the recovery position and The officer went to the wing office to telephone for an emergency ambulance. Two more officers then joined their colleagues in the room.

37. The two officers commenced cardio pulmonary resuscitation (CPR) with mouth to mouth resuscitation and were re-joined by an officer. The officers then took turns administering CPR. (A defibrillator was not used by the officers. A defibrillator is a machine that delivers an electric shock to the heart.) The SO went to the wing office and spoke to the Ambulance Service by telephone, to inform them of the severity of the man condition. The SO then made his way to the gate (the main entrance of The Verne) to meet the ambulance and escort it to the man. The man's friend was taken to the room of another prisoner, so he could be cared for following the collapse of his friend. The prisoner is a Listener, which is Samaritan trained prisoners able to offer support to other prisoners in times of crisis.
38. At 11.24pm, a paramedic arrived at the cell and began to examine the man. The paramedic asked the officers to move the man into the corridor area of the wing to give more room and took over the medical responsibility for the man care. The officers continued to assist with the CPR until the arrival of two ambulance technicians.
39. Despite emergency medical care, the man was pronounced dead at 00.17am on 14 July by the paramedic. He spoke to the man's friend and told him of his friend's death and offered to take him to see the man. He was too distressed and therefore declined to see the man.
40. The man's friend remained in the Listener's room for several hours being supported by his friend and the officers. At 5.00am, he was taken to the Listener's suite for some rest and accompanied by two more Listeners who continued to support him. A hot de-brief was held at 1.50am by the Duty Governor with a member of the staff care team and all personnel that had assisted in the man's collapse.
41. No next of kin were traceable through prison records and so the chaplain arranged the funeral and a memorial service which was held in the prison chapel.

ISSUES

42. A review of the man's healthcare was undertaken by a doctor on behalf of Dorset PCT. The doctor examined the man's medical records and the events leading to his death.

Clinical care

43. The doctor noted that the man had high blood pressure, raised cholesterol, angina, depression, breast enlargement and an epididymal cyst. (An epididymal cyst is a growth of non malignant cells in the testicle.) It was also recorded that The man was mildly overweight and a smoker. However, the doctor said that none of those illnesses were verified from an outside source.
44. The man regularly attended healthcare for appointments with the doctor and nurses. He was offered help to stop smoking and given dietary advice to lower his cholesterol. The man was supported by healthcare staff when he experienced difficulties with anxiety and depression. The doctor noted that all the man's medical complaints were dealt with appropriately and promptly.
45. The doctor said:
- “The medical notes are kept in computerised format and are, therefore, clear, chronological and annotated with the name and profession of the person with whom the man consulted. The notes are of a good quality. The care the man received was comparable to what he could expect in the community and the advice of National Service Frameworks for Hypertension and Coronary Heart Disease were followed. An additional consideration, however, could have been made by the prison medical service of referring him [the man] for a cardiological assessment in view of his angina and high blood pressure readings.”
46. The post mortem report listed the man's cause of death as coronary artery thrombosis, alongside diseased heart arteries. This was consistent with the man's medical history and his failure to stop smoking. His collapse on the evening of 13 July was due to a massive cardiac attack which was confirmed from the statements by the witnesses for that evening. The doctor noted that, in his opinion, the epididymal cyst and infection were not a contributory factor to the man's death.
47. the doctor concluded his review by suggesting three areas that could be examined and said :
- “I am aware there are problems obtaining medical record records of prisoners prior to their sentence, but I believe every effort should be made to verify a prisoner's account of their medical problems.
 - “Chronic disease management is an important component on primary care and although the man's high blood pressure and angina was

managed adequately at an individual level, I did not gain the impression there was a system in the prison to manage all prisoners who have vascular disease.

- “The man died at a relatively young age of a disease which was known to be present and symptomatic (if not consistently) for at least two years. I felt consideration for a cardiological opinion should have been considered as he was experiencing symptoms despite standard medical treatment.”

48. The doctor wrote that none of those factors suggested that the man's care was compromised through being in prison. I note the findings of the clinical review and ask that the Head of Healthcare and Governor consider the doctor's comments.

Response to the man's collapse

49. Four officers attended to the man following the emergency alert from the OSG. The SO and one officer moved the man from the bed onto the floor and were joined by two more officers. At around 11.15pm, these two officers started mouth to mouth resuscitation and CPR and were re-joined by the officer. On the arrival of the paramedic, the three officers continued with CPR until 11.40pm when the ambulance personnel joined them. The officers remained with the man, continuing to offer help until he was pronounced dead at 00.17am the next day.

50. There are no healthcare or nursing staff on duty during the night shift at The Verne. Following the man's death the officers continued to work the night duty and ensured his friend and the Listener were cared for.

51. I am satisfied that the SO managed the emergency to a high standard. He supervised prison staff and ensured that the paramedics had immediate access to the prison on their arrival. Later, he supported staff and prisoners following the man's death.

The SO and three officers who responded to the man's collapse in a professional manner and their attempt to resuscitate him is noted as good practice. Furthermore, I note the care they afforded to the man's friend and Listener.

Use of defibrillator

52. A defibrillator was not used in the resuscitation attempt on the man. The Listener told the investigator that he thought it would be useful to have defibrillators on all the wings. A previous death in custody at the Verne raised recommendations about the lack of defibrillators in the prison and one defibrillator is now sited in the healthcare unit. A second defibrillator is on order and will be located outside the healthcare centre in a central location for easy access in an emergency.

53. It is clear from the clinical review that the man had a massive heart attack and received prompt attention from prison staff who used appropriate resuscitation techniques. However, as no healthcare or nursing staff are on duty during night shift I recommend that at least one night shift officer is trained to use the defibrillator and is aware of its location..

At least one member of staff on night duty should be trained in the use of a defibrillator and be aware of its location in the prison.

Care of the prisoners following the man' death

54. His friend was deeply affected by the man' death. Following the man's collapse on 13 July, his friend was taken to the room of a Listener for support and care. The Listener told my colleague that the friend was distressed by the man's serious condition. Later, a paramedic came to see the man's friend and told him that the man had died. An officer then visited the friend to see how he was and if there was anything the officers could do to help.
55. The man's friend was allowed to remain with the Listener throughout the night. The officers gave them tea making supplies to aide their comfort and continued to check on the man's friend's wellbeing. He was moved to a Listeners suite, in another part of the prison, at 5.00am to get some rest. He was accompanied by two Listeners to continue his care.
56. The Listener told my colleague that he was given an opportunity for a de-brief with a Samaritan and the care offered by C wing staff had been excellent. Furthermore, a governor clarified questions he had following the man' death and gave her support to himself and the friend. I am pleased to acknowledge the care given by prison and C wing staff to support the man's friend and the Listener in the days following the man' death.

Next of kin information

57. The man did not offer any next of kin details to the prison on his reception. His file only noted his solicitor, who acted for his criminal case, as a next of kin. When contacted the solicitor was unable to offer any information on relatives or friends of the man.
58. Prison records showed that he did not receive any visitors. This was supported by his friends who told the investigator that the man did not have any contacts outside of the prison.
59. I suggest that the prisoner's records should be annotated to show that they do not wish their next of kin to be named or contacted.

CONCLUSION

60. The man was suffering from heart related disease and, despite being advised to stop smoking, continued to do so. He was unhappy about the PCTs decision not to fund his breast surgery and found prison life challenging. However, he eventually settled at The Verne and made some close friends. It is sad that no family details were known to prison staff and that he did not have any contacts outside of prison.
61. The response from prison staff to the collapse was timely and carried out in a professional manner together with the support they provided to the prisoners affected by the man's death. Like the clinical reviewer I am satisfied that the medical care the man received was equitable to that in the community.

RECOMMENDATIONS

For the Governor

At least one member of staff on night duty should be trained in the use of a defibrillator and be aware of its location in the prison.

Partially accepted – “Oxygen and other emergency healthcare equipment are now located in the Segregation Unit in the centre of the prison. The defibrillator is located in the Healthcare unit. Another is on order. It has been considered that the present system of having the defibrillator in the Health Care where trained staff can access it, is at present more appropriate. However, Emergency Kits are being provided by the PCT on the wings.”

Good Practice

1. The SO and three duty officers responded to the man's collapse in a professional manner and their attempt to resuscitate him is noted as good practice. Furthermore, I note the care they afforded to the man's friend and the Listener .

Accepted

2. I acknowledge the care given by prison and C wing staff in their support of the man's friend and the Listener in the days following the man's death.

Accepted

3. I would ask the Governor to ensure that when a prisoner does not want any next of kin details to be recorded their file should be endorsed appropriately.

Accepted

