Investigation into the circumstances surrounding the death of a man at HMP Bure in July 2011

Report by the Prisons and Probation Ombudsman for England and Wales

May 2012

This is the report of the investigation into the circumstances surrounding the death of a man at HMP Bure. He became unwell during an exercise class one evening in July 2011. The post mortem report revealed that he died of heart disease caused by the build up of fatty deposits in the arteries leading to the heart. He was 54 years old. I extend my condolences to his family and friends.

The investigation was conducted by two of my investigators. A review of the clinical care provided to the man at Bure was commissioned by NHS Norfolk. I am grateful to the clinical reviewer for her review. I apologise for the lateness of this report.

I would like to thank the Governor of Bure and her staff for their assistance with the investigation.

In August 2010, the man was recalled to prison having broken the conditions of his release on licence. He arrived at Bure in September of that year. He was a smoker and had a history of drug use, however, he appeared to be a relatively fit and healthy man. He was a regular and enthusiastic gym user.

On a day in July, the man had an appointment with a locum doctor because he had been experiencing chest pains and shortness of breath. Records show that the locum doctor failed to examine him properly, but nursing staff did and tests showed no signs that he had a serious heart problem. He was told not to exercise until further tests had been conducted. However, he chose to ignore the advice and went to a gym class two hours later, during which he collapsed and subsequently died.

This is the first death to have occurred at Bure since it opened in 2009. We agree with the clinical reviewer that overall the man received a level of clinical care equitable to that he might have received in the community. However, we make eight recommendations as a result of the investigation. Most relate to healthcare processes, although two concern aspects of the emergency response. I do not think that any would have changed the outcome for this man.

I am very grateful to the man's brother for considering the report at the draft stage. He continues to have concerns about the care his brother received at Bure. This final version of the report reflects the National Offender Management Service's (NOMS) response to the recommendations made.

This version of my report, published on my website, has been amended to remove the names of the man who died and those of staff and prisoners involved in my investigation.

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

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SUMMARY

1. The man was convicted of serious offences in 2007 and sentenced to five years in prison. He was automatically released at the half way point of his sentence. In 2010, he breached the conditions of his licence and was recalled to prison to serve the remainder of his sentence. He arrived at HMP Belmarsh in August of that year, transferring to Bure the following month. His health was assessed on his arrival at both Belmarsh and Bure and he said he had no immediate health concerns. He denied experiencing any chest pains.

2. The man smoked cigarettes and had, in the past, used drugs. He also complained of some mental health problems such as memory loss and anger management issues. Apparently, he found using the gym helped with both problems. He was an enthusiastic gym user who attended regular exercise classes. Staff said that he liked to challenge himself and worked very hard during his gym sessions.

3. On an afternoon in July 2011, the man had an appointment with a temporary doctor at Bure. It seems that he had been experiencing chest pains and shortness of breath over the preceding few weeks. The doctor failed to properly examine him. On leaving the appointment, the man told a nurse about his symptoms. Because nursing staff were not confident of the doctor's abilities, the nurse decided to conduct some tests to check the man's health.

4. The nurse checked the man's heart and discussed his symptoms with a nurse practitioner (who is a more highly qualified nurse). The nurse practitioner was satisfied that the tests did not indicate that the man had any serious heart problems. However, she suggested that he undergo blood tests the following day. The man was told this and advised not to exercise until the results of the blood tests were known.

5. On returning to his cell, the man told a friend that he was not feeling well and had been advised to "take it easy". However, less than two hours later he went to the gym to take part in a circuit training session. Gym staff were not aware that he had been advised against exercising.

6. During the session, the man became unwell. As his condition deteriorated, gym staff asked for healthcare staff to attend. When the man fell unconscious, the nurses and gym staff tried to resuscitate him. Paramedics arrived and continued the resuscitation attempts. Sadly, they were not successful and the man's death was pronounced at 7.40pm.

7. We make eight recommendations as a result of this investigation, however, we find that the man received a level of clinical care equitable to that he might have received in the community. The recommendations are largely focused on improving healthcare process although two concern responding to emergency situations. We do not think that any would have prevented the man's death.

THE INVESTIGATION PROCESS

8. The Ombudsman's office was notified of the man's death on 25 July 2011 and the investigation was allocated to a senior investigator. The senior investigator and her colleague visited Bure on 29 July 2011 to open the investigation.

9. During this visit they met with the Deputy Governor, the Prison Liaison Officer, a representative from the Independent Monitoring Board (IMB - a body of local people who independently monitor and report on the prison and explained in more detail below), a representative from the Prison Officers' Association, the healthcare contract manager and the Prison Family Liaison Officer. They also used this opportunity to look around the prison, particularly the gym where the man died, the healthcare centre and B wing where he lived. The investigator was given copies of the man's prison and medical records.

10. Notices were issued announcing the investigation to staff and prisoners. The notices included an invitation to prisoners who wished to share any information relating to the man's death, to make themselves known to the investigator. Two prisoners came forward as a result of these notices and were interviewed.

11. The investigator contacted Her Majesty's Coroner to inform him of the nature and scope of the investigation and request a copy of the post mortem report. The Coroner will be provided with a copy of this report to assist with his inquiries.

12. NHS Norfolk commissioned a clinical reviewer to undertake an independent clinical review of the man's medical care at Bure.

13. In September, staff and prisoners were interviewed at Bure. Some of the interviews were jointly undertaken with the clinical reviewer. The doctor who saw the man on the day of his death was a locum General Practitioner (GP), employed by an agency. He was no longer working at the prison and we were unable to trace him to interview as part of the investigation. Following interviews the Governor was given verbal and written feedback on the process of the investigation.

14. One of the Ombudsman's Family Liaison Officers (FLO), wrote to the man's brother on 17 August. She explained the purpose of the investigation and provided him the opportunity to raise any questions or concerns he had about his brother's time at Bure. On 22 of August, the Family Liaison Officer received a telephone call from the man's brother. He spoke positively of the prison, telling her that he felt that the prison did everything that they could under the circumstances. However, he raised two questions that he asked to be looked at as part of the investigation. He said that, after his death, his brother's right ear looked swollen. He asked whether his brother had fallen on this side of his head when he collapsed. He also asked whether his brother's heart attack could have been brought about by his frequent gym use.

15. The man's brother commented on the draft version of the report. He remains disappointed with the medical care his brother received at Bure. He is concerned that healthcare staff did not act sooner given that his brother was complaining of

chest pains. He is also concerned about some aspects of the emergency response when his brother collapsed. He hopes that systems have now been improved. He has forwarded a number of questions to the Coroner for consideration during the inquest.

HMP BURE

16. HMP Bure is a specialist category C prison for adult men convicted of sexual offences. (Adult male adult prisoners are given a security categorisation soon after they enter prison. These four categories are based on a combination of the individual's risk and their length of sentence. Category C prisoners are those who cannot be trusted in open conditions but who are unlikely to try to escape). Bure is situated on a former RAF site a few miles from Norwich. The prison first began to admit prisoners in November 2009 and can hold up to 523 prisoners.

Healthcare

17. Health services were initially commissioned by NHS Norfolk. Primary health services were provided by Norfolk and Community Health Care Trust and mental health services by Norfolk and Waveney Mental Health Foundation Trust. However, Serco (a private company) has now taken over the management of a variety of healthcare providers.

HM Chief Inspector of Prisons (HMCIP)

18. Bure has undergone one inspection by HMCIP since it opened. The inspection took place in September 2010. The ensuing report was generally positive. HMCIP noted that the opening of the prison had gone smoothly and that Bure was a "well managed establishment" with a "proper focus" on addressing the prisoners' offending behaviour. Staff were praised for their "professional" and "thoughtful" approach to their work.

19. HMCIP found the PE department to have "excellent" links with healthcare. At the time of the inspection, Serco were not yet managing the healthcare contracts and so we do not cite aspects of the report focusing on healthcare here.

Independent Monitoring Board (IMB)

20. Every prison in England and Wales is monitored by a board of unpaid members, appointed by the Secretary of State for Justice. The role of the IMB is to ensure proper standards of decency and care are afforded to those held at the prison. They must provide an annual report to the Secretary of State. The most recent available report for Bure covers August 2010 to July 2011.

21. The IMB reported that the provision of healthcare at Bure was "in the main, good". In fact, the Board was largely positive about all aspects of the regime at Bure. They particularly noted staff enthusiasm and commitment to their work.

22. This is the first death to have occurred at Bure since it opened in 2009.

KEY EVENTS

23. The man grew up with eight brothers in South London. He worked predominantly as a labourer or in sales. He had an extensive offending history, and had spent several periods in custody. In September 2007, he was convicted of theft and sexual offences and was sentenced to five years in prison. He was released from custody on 18 November 2009 having served half of his sentence. However, on 19 August 2010, he was recalled to prison to serve the remainder of his sentence because he had not complied with the conditions of his licence.

24. On his arrival at HMP Belmarsh, the man was assessed by a nurse who carried out the First Reception Healthscreen (which identifies any immediate mental or physical health needs). The nurse recorded that the man had no concerns about his physical health and had not seen a doctor in the last few months. One of the healthscreen questions asks about chest pain. The man told the nurse that he was not experiencing any such pain. He was not prescribed any medication while at Belmarsh and, apparently, had no health complaints.

25. The man was transferred from Belmarsh to Bure on 29 September. On his arrival, he was assessed by a nurse. The nurse recorded that the man had no immediate health concerns. She noted that he was a smoker and had misused drugs in the past. She measured his pulse (which was normal at 62 beats per minute) and his blood pressure. The man's blood pressure reading was 155/85mmHg and showed that he had relatively high blood pressure. (According to The British Heart Foundation, an adult's blood pressure should ideally remain below 140/85mmHg.) The nurse recorded that the man was fit to use the gym. The nurse wrote that the man was not prescribed any medication. He said that he did not want to see the doctor.

26. On 2 October 2010 the man undertook a gym induction. This induction is made up of three parts. The first part is the actual gym induction, where prisoners are introduced to rules and regulations of the gym and shown how to use the equipment. The second part is a 'Heartstart' presentation which consists of basic first aid and manual handling. The final part is the completion of all relevant paperwork specific to gym regulations.

27. The man signed the HMP Bure Physical Education Compact. (This document sets out the rules and regulations in the gymnasium. Prisoners wishing to use the gym must sign to indicate that they understand them. The rules and regulations relate to proper use of the equipment and health and safety). He also completed the Physical Activity Readiness Questionnaire (PAR-Q). This form requires the prisoner to highlight any health concerns that might affect whether they should use the gym. In signing this document the man agreed that it was his responsibility to notify staff of any change to his medical condition. In particular, he agreed to notify staff if he was suffering any illness (such as a cold or fever), was not feeling well when using the gym or was recovering from an injury or surgery.

28. A Physical Education Instructor (PEI) was interviewed as part of the investigation. He explained that prisoners wishing to use the gym are told that the PAR-Q form

is the most important part of the gym induction process, as it is based around their health and level of fitness. Prisoners must tick yes or no to the nine questions contained in the questionnaire. The PEI explained that a lot of the questions focus on heart conditions (in fact four of the nine do so), but there are also general health questions.

29. A Physical Education Senior Officer (PESO) was also interviewed. He explained that, if a prisoner answers "yes" to any of the nine questions, the form is sent to the healthcare department. In such cases, healthcare staff must provide further information about whether it is safe for the prisoner to use the gym. Healthcare staff must indicate (again by tick box), at what level the individual can use the gym facilities. They range from fully fit, which would allow the prisoner to use all of the facilities, to remedial, where gym usage is encouraged to help the prisoner to recover from certain health problems. The PESO acknowledged that PE staff rely on prisoners to be truthful about their health conditions. He explained that the same system applies if an individual joins the gym in the community. The PAR-Q is only completed once, at the induction stage. The man ticked "no" to all nine questions, indicating that he had no existing health problems which might affect his gym usage.

30. On 1 April, the man had an appointment with a doctor. The man was told that he was Hepatitis C positive in mid-April. (Hepatitis C is an infectious disease primarily affecting the liver. It is normally treated with tablets and a course of injections.) He was referred to the local hospital for assessment and was awaiting news of his treatment plan.

31. By all accounts, the man was a very keen and regular gym user. The PEI said that he was "always" at the gym, "come hell or high water". The PEI said that the man was "not the fittest" prisoner but that he enjoyed his gym sessions and did various different activities there. In particular, it seems that he enjoyed the circuit training sessions and Iron Man club (which is more physically challenging than circuits). The PEI said that, sometimes, the man had to be reminded about the correct exercise techniques because his technique was "head on, 100 miles per hour".

32. Entries in his medical record indicate that the man found using the gym helpful in addressing some mental health problems that he suffered from. In October, he was assessed by a mental health nurse. The nurse wrote that the man was experiencing periodic long and short term memory loss. The man also said that he sometimes felt disorientated. He said that physical exercise helped and particularly a "vigorous" gym session. The nurse recorded that the man was not depressed or unduly anxious and had no signs of any psychosis. (Psychosis is a condition that affects a person's mind, a person who suffers from such a disorder may be unable to distinguish between reality and their imagination)

33. During the investigation, the man's friend and a fellow prisoner, was interviewed. The fellow prisoner said that he had first met the man at another prison. He explained that the man used the gym a lot and that, in his opinion, sometimes pushed himself too hard. However, the fellow prisoner thought that he used exercise to manage his anger.

34. The PESO told the investigator that the man began regularly attending the circuit training sessions on 9 May. He explained that prisoners complete an application form detailing the particular sessions they would like to attend. Prisoners who miss two consecutive sessions without good reason or informing gym staff are removed from the session list. The man missed two circuit sessions in July and was taken off the list. His name was placed back on the list on 21 July.

35. The PEI was asked whether, prior to the day of the man's death, he had ever had reason to worry about the man's health. He replied that he had not.

36. On 20 July, a healthcare assistant took the man's pulse and blood pressure readings. In interview, the healthcare assistant explained that, on that date, the prison was holding a well-being day at the gym. As part of the event, prisoners could have aspects of their health checked. She recorded that the man's pulse rate was 73 beats per minute and his blood pressure was 160/81mmHg (again this indicated that he had relatively high blood pressure). There is no evidence that healthcare staff took any action in the light of his blood pressure reading.

Events on the day of the man's death

37. At 2.37pm on a day in July, the man attended an appointment with a doctor. As previously noted, the doctor was a locum, employed by an agency. (Locum doctors are normally used to cover a regular doctor's absence. They may cover lengthy absences or be placed somewhere for a very short time, for example to provide holiday cover.) The doctor had been working at Bure for a couple of weeks while the regular doctor was on holiday.

38. The doctor recorded that the man's appointment was in relation to his Hepatitis C status. In his very brief note of the appointment, the doctor wrote that the man had almost no symptoms of the virus. He made no record of the man raising any other issues during the appointment.

39. The healthcare contract manager at Bure was interviewed as part of the investigation. He told the investigators that, if a prisoner wants an appointment with the doctor, they must complete a paper application. Once healthcare staff have received the application, the prisoner is booked an appointment in one of the clinic sessions. No information about why the prisoner wants to be examined by the doctor is recorded in the prisoner's medical record. The healthcare contract manager explained that it is up to the prisoner to discuss symptoms or concerns with the doctor during the appointment. The doctor does not know in advance the specific nature of the problem. The healthcare contract manager explained that this is the same system in place in community doctors' surgeries.

40. Unfortunately, prisoners' applications are destroyed once the appointment has been booked. As a result, the investigation team was unable to view the application that the man completed when he requested the appointment. However, the healthcare contract manager said that healthcare staff understood that the man had been experiencing some chest pain over the weekend and had requested an appointment as a result.

41. The man's friend and fellow prisoner was asked whether the man mentioned feeling unwell over the weekend. He said that his friend had seemed his normal self and did not say that he was unwell.

42. The man left the appointment with the doctor and, at around 3.15pm passed a nurse in the foyer. He stopped the nurse and asked if he could speak to her. This nurse was interviewed as part of the investigation. She explained that the man said that "he was a little bit concerned" that he had seen the doctor because he was experiencing chest pains. He said that he had been having chest pains "on and off" for several weeks. He told her that he sometimes felt a bit short of breath and that he was concerned because the doctor had not examined him. She described the man as "playing it down", telling her "it's nothing mind" and "it's probably indigestion". The nurse said that she asked him if he had chest pain at that moment and he said he did not.

43. The nurse said that his description of his symptoms "rang alarm bells" given his age and that he smelt of cigarettes, meaning he was probably a smoker (both factors increase the risk of heart problems). She decided to assess the man that evening by undertaking a set of observations and an ECG (electrocardiogram - a test that measures the electrical activity of the heart and records the heart's rhythm). She told the man to return to his wing and said that she would come and collect him later for the ECG.

44. On leaving the man, the nurse went to speak to the healthcare contract manager to explain what had happened and express her concerns about the locum doctor's practice. The healthcare contract manager made the decision to suspend the doctor's clinic immediately. In interview, he explained that nursing staff had "lost considerable confidence in the abilities and communications" of the locum doctor. He said that it seemed the doctor "had difficulty communicating with the patient population and being understood". That afternoon, the healthcare contract manager contacted the agency which had supplied the doctor and told them that he did not want him to return to the prison. He also expressed concerns about the doctor's communication skills. The healthcare contract manager said that, as far as he was aware, the locum doctor was no longer employed by the agency. The records of all prisoners who had been examined by the locum doctor were later reviewed by another doctor and some were recalled for further examination.

45. The nurse told both the healthcare contract manager and the nurse in charge at the time of her plans to review the man later. The nurse in charge agreed with her plan and so the nurse called the man back to the healthcare centre. At 3.32pm, the nurse assessed him. His pulse was 68 beats per minute and the ECG recorded his blood pressure as 160/100mmHg. The nurse said that his blood pressure reading "alarmed" her somewhat and so she sought advice from a nurse practitioner. (Nurse practitioners have undertaken specific advanced nursing education, such as a doctoral or masters degree. As such they may carry out a wider range of responsibilities than general nurses.) During interview, the nurse said that she has been trained to undertake ECGs, but not to interpret

them, and would, therefore, always show the results to a doctor or nurse practitioner.

46. The nurse practitioner was also interviewed as part of the investigation. She explained that, at Bure, the prison doctors manage patients with complex needs or those with substance misuse problems. Nurse practitioners manage those patients who have slightly less complex needs, with general nurses managing patients requiring minor interventions. She said that, normally, if a nurse carries out an ECG they will ask one of the doctors to review the results. However, she said that the nurse practitioners have a good working relationship with the general nurses and are often asked for advice or to see extra patients.

47. The nurse who carried out the ECG told the nurse practitioner that the man had been seen by a locum doctor, having experienced chest pains over the weekend, but that the doctor had not carried out a thorough examination. She explained that she had, therefore, decided to perform the ECG because she thought the doctor should have. The nurse practitioner said that she asked the nurse if the man was still experiencing chest pain and was told that he was not.

48. The nurse practitioner examined the ECG report, checking the recorded heart rhythm and for any signs that the man had suffered or was suffering a heart attack. She identified some signs of heart problems but, overall, considered he was stable. She told the nurse this but suggested that he undergo a blood test, which would also test for Troponin. (Troponin is an enzyme found in the blood. Levels increase when someone has a heart attack.) The nurse practitioner told the nurse that he should be seen again if he experienced any more chest pain. The nurse practitioner explained that, had she been concerned about the ECG report, she could have conducted a full assessment of the man, or she could have called for an ambulance. The nurse practitioner did not meet the man or carry out any physical assessment of him that day.

49. The nurse told the man that he could return to his wing. In interview, she said that she emphasised that he should tell wing staff if he had any further chest pain. The nurse said that she told him that he would undergo a blood test the following day. She was quite sure that she had also told him that he should not do any exercise until after the blood test results had arrived. Although the nurse made an entry in the man's medical record, she did not record that she had advised him against exercise.

50. During interviews, the nurse and the nurse practitioner were asked whether healthcare staff routinely informed PE staff if a prisoner is not well enough to use the gym. The nurse said that, if a prisoner is merely warned against exercise or using the gym, it is ultimately his decision whether to heed the advice or not. However, she explained that staff can complete a form if they consider that the prisoner is not fit to use the gym. In such cases, the form is passed to PE staff and the prisoner can be prevented from undertaking gym activities. The nurse practitioner said that, if she was very concerned that a prisoner should not exercise, she could telephone PE staff and ask that the prisoner be stopped from using the gym. However, she agreed that the prison tries to foster a sense of

responsibility among prisoners. The nurse told the investigators that she did not consider it necessary to formally prevent the man from exercising.

51. Both members of PE staff who were interviewed agreed that they were informed if a prisoner had been formally deemed unfit to attend gym. However, they said that they were not normally told if a prisoner had been advised not to exercise.

52. The man's friend and fellow prisoner saw him on his return from healthcare. He told the investigators that his friend said he had been advised to "take it easy". He said that his friend told him he was feeling "dodgy" and had high blood pressure. However, he left for the gym sometime later. He thought that his friend would have gone to his gym class even if he was feeling unwell.

53. At about 5.30pm, the man went to the gym for the evening circuit training class, which was led by a PEI. In interview, the PEI said that he had not been told that the man should not attend the session.

54. In line with gym protocol, the PEI asked those present if they had any injuries or problems that might affect their full participation in the class. No one reported any issues or concerns at this time. In interview, the PEI said that the man gave no indication of ill health. The PEI took the class through a warm up and then began the circuit training.

55. About 15 minutes into the session, the PEI noticed that the man was not exercising, but was standing at the end of the hall. The PEI asked if he was okay and the man told him that he felt light headed. The PEI asked him if he had pains in his chest, which he denied. He advised the man to rest for a while, drink some water and sit by the door to get some fresh air. The man went to sit in the gym foyer.

56. Very shortly after, a prisoner employed to work in the gym told the PEI that the man did not look well. The PEI said that he spoke with the man, who appeared to have poured water over his head to try to cool himself down. The man said that he was still feeling dizzy and hot. The PEI advised the man to sit on the stairs but he insisted that he was fine. In fact, throughout, he repeated that he was fine and would rejoin the class once he was feeling better. The PEI asked the prisoner employed to work in the gym to watch the man so that he could return to supervise the rest of the class.

57. Not long afterwards, the prisoner employed to work in the gym told the PEI that the man "was not right", so the PEI returned to see him in the foyer. The PEI said that the man was sitting on the stairs, but was now leaning against the wall to his left, with his arm tucked around him. Again, the PEI asked him if he was okay and the man said that he was fine. The PEI asked if he had any chest pains and he said he did not.

58. The next time that the PEI checked the man, he was moaning slightly. He asked him if he was still feeling dizzy and whether he had any pains in his chest and left arm. He confirmed that he had some pain in his chest, but not his arm. The PEI immediately told the prisoner employed to work in the gym to alert a further PEI

(who was also working in the gym) of the problem and ask him to call healthcare as a matter of urgency. The PEI continued to talk to the man, who insisted he was fine and wanted to be left alone. He advised the man to sit on the floor with his back against the wall and his knees bent (known as the W position, this is recognised good practice if someone has chest pains). However, the man said he felt more comfortable sitting on the step.

59. Between 6.20pm and 6.30pm, the radio call for healthcare assistance was made. (Staff statements, based on their recollections gave a variety of times for the initial call to healthcare, for the purpose of this report we have assumed the call was made between 6.20pm and 6.30pm.) The nurse who had carried out the man's ECG was the designated emergency response nurse that afternoon. She was in the exercise yard talking to prisoners and initially did not hear the radio call. The healthcare assistant took the emergency healthcare bag, found the nurse and alerted her to the call. The nurse said that, when she saw the healthcare assistant, she realised that it was an emergency.

60. Nursing staff said that a code system is in place at Bure. Code Blue indicates that a prisoner is having difficulty breathing; Code Red indicates that a prisoner is bleeding. (Most prisons have a code system for use in medical emergencies. Use of the codes enables medical staff to attend the emergency with the correct equipment.) The staff interviewed confirmed that a code blue was not used when the initial call was made to healthcare. The PEI said that he did not consider using the code system as, at the time the call was made, he did not think that the man was seriously unwell.

61. The nurse arrived at the gym and saw the man sitting on the stairs. The PEI remembered that she asked what the man was doing there, explaining that she had seen him in the healthcare centre that day and told him not go to the gym. The nurse said that she immediately knew the man was seriously unwell and asked staff to call an ambulance straightaway. The nurse told the man that paramedics were on their way and he said that he was fine and had indigestion. She described the man as cold, clammy and said that he had very low blood pressure. The nurse used her radio to ask the healthcare assistant to bring the oxygen from the healthcare centre. A second nurse was also in the healthcare centre and followed the healthcare assistant back to the gym.

62. The nurse said that she was trying to calm the man when he suddenly said that he no longer had any pains in his chest. The nurse asked someone to find a wheelchair so that he could be moved to the healthcare centre. He sat in the wheelchair and shortly after, the chest pains returned. Both nurses gave him oxygen. The nurse who had earlier carried out the man's ECG asked the healthcare assistant to fetch the defibrillator from the healthcare centre. (The prison is equipped with several automated external defibrillators (AEDs) which can, in some circumstances, deliver an electric shock to the heart to establish a normal rhythm.)

63. At 6.36pm, an operational support grade (OSG), who was working in the prison control room, was asked to call 999 for an emergency ambulance.

64. At about 6.45pm, the man clutched his chest and lost consciousness. The nurses asked staff to help them place him on the floor. He vomited and his skin began to turn blue. The two PEI's and the second nurse undertook cardiopulmonary resuscitation (CPR) whilst the nurse who was first on scene held the mask on his face to supply oxygen. (CPR is the delivery of chest compressions and rescue breaths to someone who is not breathing.)

65. Whilst staff were attempting to resuscitate the man, the local ambulance service telephoned the control room to ask for an update on his condition. The nurse who was first on scene had to leave the man to speak to ambulance service staff. She told them that resuscitation was underway.

66. When emergency calls are received by the ambulance service, staff dealing with the call may despatch a first response paramedic (who normally travel by motorbike or car) who will be able to reach an emergency scene more quickly than the ambulance crew. At 6.45pm the first response paramedic car arrived at the gym. One PEI continued giving chest compressions to the man, whilst the other PEI held the oxygen mask. The prison nurses helped the paramedics.

67. In interview, the second nurse on scene said that the paramedics set up their own defibrillator and ECG machine. The defibrillator (which gives audible instructions to staff using it) advised that no shock should be delivered (because the man's heart was not beating). The paramedics tried to administer adrenalin (this is a medication used in advanced life support) and get fluid into the man's system, but they were unable to locate a vein.

68. At 7.00pm, an OSG called 999 for an update on the ambulance's location. He was told that it was six miles away. The ambulance crew arrived at Bure at about 7.18pm, and paramedics continued to try and resuscitate the man. He was treated with adrenalin. Unfortunately, despite the efforts of the prison staff and paramedics, he could not be resuscitated. At 7.40pm, the paramedics pronounced that the man had died.

Contact with the man's family

69. On his reception to prison, the man said that he wanted his brother, who lived in London, to be contacted in the event of an emergency. Following his death, the Governor considered whether Bure staff should travel to London or whether staff at HMP Wandsworth could be asked to visit the man's brother. (Bure is located in rural Norfolk and it would have taken staff over three hours to drive to London, therefore delaying breaking the news.) According to Prison Service Order (PSO) 2710 - Follow up to a death in prison, prison staff may seek assistance from prisons that are geographically closer to the next of kin. However, staff at Bure were not sure that the contact details the man gave for his brother were correct as he had given two different addresses.

70. Staff contacted Norfolk Police who provided the Metropolitan Police with the two addresses. Metropolitan Police staff were unable to find one address and said that the other did not exist. As a result, the Governor gave permission for the nominated prison FLO to contact the man's brother by telephone. Telephone

contact was made on 26 July. During the conversation the man's brother asked for a home visit to discuss the events. The prison FLO and his colleague visited the man's brother on 28 July. In line with PSO 2710, the prison remained in contact with the man's next of kin and assisted the family with funeral arrangements.

Support for staff and prisoners

71. The Governor met with all staff who had been involved in the emergency response, and other staff and prisoners affected by his death. (Holding such a meeting is in line with PSO 2710 and provides an opportunity for all those involved to discuss their experience and gain support where needed.) Staff who we spoke to as part of the investigation all spoke positively, not only of the support they were given by their immediate colleagues, but also the support they were offered by managers at Bure.

72. Prisoners were told of the man's death by way of note from the Governor which was placed under each cell door. The man's friend and fellow prisoner said that officers on his wing told him personally that his friend had died. He was aware of the support available to him if needed.

Results of the post mortem

73. The post mortem report established that the man died as a result of ischaemic heart disease due to coronary artery atheroma. (Ischaemic heart disease is also known as coronary artery disease. It is a condition in which atheroma (fatty deposits) build up in the linings of the walls of the coronary arteries. This causes a narrow artery and reduced blood flow to the heart muscle.)

ISSUES

Clinical care

74. As part of the investigation, a clinical reviewer conducted a review of the clinical care the man received at Bure. She concludes that his care was equitable with that he would have received in the community. Her review covers a range of healthcare issues identified at Bure that relate specifically to this man's care, some of which we discuss and repeat. Those that relate to the wider provision of healthcare at Bure, we draw to the head of healthcare's attention.

75. The man had been in prison since his recall in August 2010. His health needs were assessed at Belmarsh that month and, the following month, when he arrived at Bure. On both occasions, he denied any history of chest pains.

76. On two occasions prior to his death, the man's blood pressure was monitored. The readings indicated that he had relatively high blood pressure but, apparently not high enough to cause concern. He was not offered any treatment as a result of the blood pressure readings.

77. The man was in his 50s and he smoked cigarettes. Both increasing age and smoking increase the risks of heart disease. However, he was, by all accounts, a fit man who regularly used the gym (which can help to reduce the risk of heart problems). He apparently found using the gym helpful in managing his memory loss and anger issues.

The locum doctor's assessment

78. Anecdotal evidence suggests that over the weeks preceding his appointment with the locum doctor on the day of his death, the man had been experiencing chest pains and shortness of breath. However, it seems he did not seek an earlier appointment. Unfortunately, the investigators were not able to view his application for an appointment as applications are destroyed once the appointment has been made. This document might have helped to confirm why he wanted an appointment with the doctor. The nurse who carried out the man's ECG told the investigators that the appointment was to investigate his chest pain. However, the locum doctor's note in the medical record makes no mention of chest pains, only recording details of the man's Hepatitis C status.

79. At the time of the man's death, Bure did not have a permanent doctor and the regular locum doctor was on holiday. The healthcare contract manager said that the locum doctor was only at the prison for approximately two weeks. During his short time there, nursing staff had lost confidence in his skills and had raised some concerns with him already. However, no formal complaints about the doctor's practice had been made.

80. Following his appointment with the locum doctor, the man spoke to a nurse. She raised further concerns about the doctor's practice with the healthcare contract manager. As a result, the healthcare contract manager immediately cancelled the doctor's clinics and all further shifts at the prison. He discussed his concerns

with the agency that provided the locum doctors. The doctor is, apparently, no longer employed by the agency. We were not able to locate or interview him during the investigation.

81. We are satisfied that, when healthcare staff became concerned about the abilities of the doctor, they appropriately raised these with the healthcare contract manager. We are also pleased that prompt action was taken to ensure that the doctor did not return to Bure. Bure now have a regular locum doctor and are in the process of recruiting a permanent doctor.

82. The clinical reviewer notes that "the difficulties of recruiting [doctors] to prison healthcare teams are well known". However, clearly the recruitment of a permanent doctor must be a priority. In interview, the healthcare contract manager explained the steps he was taking to recruit a doctor and, in the meantime, ensure adequate cover and support was provided by doctors working at other nearby prisons. On that basis, we do not make a recommendation about the recruitment of a permanent doctor. The healthcare contract manager also said that, following the man's death, he had arranged, through the agency, for one locum to be in post at Bure for several months.

The healthcare contract manager should continue to liaise with the agency providing locums to ensure that, as far as possible, the locum cover at Bure is consistent and effective.

The nurse and nurse practitioner's actions

83. As a result of the man's concerns, the nurse decided to perform an ECG. Because she had little confidence in the doctor, she preferred to show the results to a nurse practitioner. The nurse practitioner was in the middle of her own clinic; however she reviewed the ECG report and briefly discussed the man with the nurse. The nurse practitioner did not find any signs that he was suffering an acute heart condition. She and the nurse agreed that he should undergo a blood test the following day, which would test for signs of severe heart problems.

84. The clinical reviewer writes that:

> "The role of the Nurse Practitioner (NP) in relation to offering support and advice to the healthcare team at HMP Bure appears confusing to some staff. There appears to be an assumption that the NP post takes responsibility for patient management. The absence of an appropriate, permanent [doctor] puts added pressure on the NP service"

The healthcare contract manager should clarify the role of Nurse Practitioners in the absence of a permanent GP provision.

85. The clinical reviewer also writes that there is currently no protocol or pathway for staff to follow if a patient presents with chest pain, although nursing staff are trained to carry out ECG examinations.

The healthcare contract manager should ensure the development of a clinical pathway for patients who present with chest pain.

86. The nurse told the investigators that she was quite sure she had advised the man not to go to the gym until the results of his blood test were known. However, she did not record this in his medical record. The clinical reviewer also notes that, although staff told the investigation team that the man had been experiencing chest pain over the weekend, no entries to this effect were made in his record. She makes the following recommendation:

The healthcare contract manager should introduce a clinical audit programme to include record keeping. Any training needs identified should be incorporated into individual development plans.

Whether the man should have been prevented from exercising

87. As noted above, the nurse was sure that she had advised the man not to exercise until his blood test results had returned. It seems that he ignored that advice and went to his pre-booked class later that evening. The investigation team has considered whether the advice was sufficient or whether formal steps should have been taken to prevent him from attending the gym.

88. In interview the nurse practitioner and nurse explained that, if healthcare staff deem a prisoner unfit to exercise, they complete a form. The form is passed to PE staff and the prisoner is barred from using gym facilities. However, the staff explained that more often, prisoners are given informal advice not to exercise and it is their decision whether to heed it or not. Staff explained that this is much like arrangements in the community.

89. Clearly, this issue requires a balanced approach. To routinely prevent prisoners from using the gym might result in fewer seeking medical advice. For many prisoners, using the gym provides an outlet for both physical and emotional energy. It is popular with many, who would resent any further restrictions on their access to it. In addition, part of the process of rehabilitation must involve encouraging prisoners to take responsibility for themselves, including their health.

90. In this man's case, he had presented with chest pain and was awaiting further results. He told his friend that he had been advised not to exercise. Even had the nurse decided to formally prevent him from using the gym, it is unlikely that she would have completed the paperwork in time to stop him from attending the circuit training session at 5.30pm that evening.

91. However, we consider that healthcare staff would benefit from clear guidance about when a prisoner should be deemed unfit for exercise.

The healthcare contract manager should ensure the development of clear guidance on the circumstances under which prisoners are formally excluded from gym activities.

The emergency response

92. On the day of the man's death, the nurse who had earlier carried out the man's ECG was the designated emergency response nurse. At around 6.30pm, PE staff requested emergency healthcare assistance because he was not well. The nurse did not initially hear the call as she was in the exercise yard and was surrounded by prisoners. However, other healthcare staff alerted her to the call and the response was not unduly delayed.

93. Although staff said that a code system is in place at Bure, no code was used to summon healthcare staff to assist the man. Use of the code system allows healthcare staff to bring the necessary equipment to the scene. On this occasion, a healthcare assistant had to return to the healthcare centre twice, first to collect the oxygen and then the defibrillator. We are pleased to note that, following this man's death, emergency medical equipment, including a defibrillator, will be located in the gym.

94. During interviews, staff said that they were confident of the code system. On this occasion, the PEI explained that he had not considered the man to be seriously ill and did not think the situation warranted a code blue call. We are satisfied that the staff involved in this incident were aware of the code system. However, in interviews, healthcare staff expressed concerns that discipline staff did not always use the code system correctly, on that basis, we make the following recommendation:

    The Governor should ensure that all staff are aware of, and make appropriate use of, the emergency code system

95. The clinical reviewer concludes that the staff attempts to resuscitate the man were appropriate. CPR was continued by both prison and healthcare staff until paramedics arrived. All healthcare staff complete regular CPR and defibrillator training. In addition, PE staff undergo first aid training. The clinical reviewer praises the good team working amongst staff at the prison.

The local ambulance service response

96. An OSG telephoned for an emergency ambulance at 6.36pm. The first response paramedic arrived about ten minutes later. However, the ambulance did not arrive for some 40 minutes. In addition, during resuscitation attempts, the local ambulance service telephoned the prison requesting an update on the man's condition. As a result, the nurse had to stop assisting the resuscitation efforts to speak to ambulance service staff. Both the length of time it took for the ambulance to arrive and the request for an update suggest that further liaison is needed between the prison and the local ambulance service.

    The Governor and healthcare contract manager should put in place an effective protocol with the local ambulance service to ensure a safe and appropriate emergency service to the prison.

Issues raised by the man's family

97. During the investigation, the man's brother said that, after his brother's death, it seemed that his right ear was swollen. He asked if this was a result of him falling to the floor. The post mortem report found no evidence of external injuries or trauma. Staff interviewed gave detailed accounts of the events on the evening of the man's death. None mentioned him falling. We are unable to explain why his right ear was swollen.

98. The man's brother also asked if the heart attack could have been the result of him attending the gym too often or whether he had a heart condition which could have resulted in his death at any time. We are not able to answer this question based on the evidence available. We appreciate that this may be frustrating for his family. However we hope that this report provides them with an understanding of the circumstances surrounding his death.

CONCLUSION

99. The man arrived at Bure in September 2010. He was a smoker in his 50s, with a history of drug use. However, during his time at the prison, he presented with few physical health problems and certainly none suggesting serious problems with his heart. He was an enthusiastic and regular gym user.

100. On the day of the man's death, he was examined by healthcare staff, having experienced chest pains and shortness of breath. Initial tests showed no signs of serious heart problems but further examinations were planned for the following day. He was advised against exercise that day but decided to attend an evening circuit training session. During the class he fell ill and stopped breathing. Prison staff and paramedics tried to resuscitate him but, unfortunately, were not able to.

101. We make eight recommendations as a result of this investigation. However, we agree with the clinical reviewer that overall the man received a level of clinical care equitable with that he might have received in the community.

RECOMMENDATIONS

The NOMS response to the recommendations is reflected in italics under each recommendation.

1. The governor and healthcare contract manager must ensure that all relevant parties are provided with a copy of the clinical review and that an action plan is devised in response to the recommendations made therein.

   This recommendation has been accepted.

2. The healthcare contract manager should continue to liaise with the agency providing locums to ensure that, as far as possible, the locum cover at Bure is consistent and effective.

   This recommendation has been accepted.

3. The healthcare contract manager should clarify the role of Nurse Practitioners.

   This recommendation has been accepted.

4. The healthcare contract manager should oversee the development of a clinical pathway for patients who present with chest pain.

   This recommendation has not been accepted.

5. The healthcare contract manager should introduce a clinical audit programme to include record keeping. Any training needs identified should be incorporated into individual development plans.

   This recommendation has been accepted.

6. The healthcare contract manager should oversee the development of clear guidance on the circumstances under which prisoners are formally excluded from gym activities.

   This recommendation has been accepted.

7. The Governor should remind staff of the appropriate use of the emergency code system.

   This recommendation has been accepted.

8. The Governor and healthcare contract manager should liaise with the local ambulance service and ensure that an effective protocol is in place.

   This recommendation has been accepted.