Investigation into the circumstances surrounding the death of a man at HMP Sudbury in September 2007

Report by the Prisons and Probation Ombudsman for England and Wales

May 2008

This is my report of an investigation into the death of a man in September 2007 at HMP Sudbury. He was aged 50. I offer my condolences to his family and all those touched by his passing.

The man had been to see prison healthcare staff in July and August 2007 after experiencing tightness in his chest. He was prescribed medication and was referred to the local hospital. Sadly, before the date of his appointment, he suffered a fatal heart attack. The cause of death has been given as 1a) myocardial infarction (heart attack), due to coronary thrombosis and severe atherosclerosis (disease affecting arterial blood vessels).

This investigation was carried out on my behalf by one of my investigators. I would like to thank the Governor of HMP Sudbury and his staff for their co-operation.

I also commissioned a clinical review into the man's medical care. This was carried out by a review team led by the Deputy Director Clinical Quality and Nursing on behalf of Derbyshire County Primary Care Trust (PCT). I am most grateful to the clinical panel for their assistance. Unfortunately, the review was delayed and I must apologise for the consequent late issuing of this report.

Overall, the medical care the man received in prison was comparable to that which he would have received in the community. However, the clinical review has highlighted areas of learning for the prison. I include these findings in my report and make five recommendations. The clinical review panel has also identified two strategic recommendations for the PCT. I have not included these in this report, but will forward them to the Chief Executive of the PCT to consider.

Stephen Shaw CBE
Prisons and Probation Ombudsman **May 2008**

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SUMMARY

The man received a three year custodial sentence in January 2007. It was his first time in prison. His medical records show that he was a generally fit and well man although he was considered to be overweight. During the prison reception process, he reported a history of knee pain and depression prior to receiving his sentence. He had been prescribed anti-depressants. No other concerns were reported.

As a classroom assistant in the prison's education department, followed by a job in the staff mess, the man was keen to further his own education whilst in custody and on his release. He was reported to be a hard worker and got on well with his peers.

During his first seven months in prison, the man had many contacts with the healthcare team. These predominately related to his knee pain, back pain and pain in his calf. Medication was given when necessary and tests were carried out where appropriate. During this time, he was also trying to lose weight. He took medication to assist, as well as exercising and attending a weight loss clinic. He had lost two stone by the time he died.

At the end July 2007, the man attended healthcare because he had experienced tightness in his chest. He returned in the middle of August for the same complaint. On the second occasion, on 14 August, he was referred to the doctor. The doctor saw him on 17 August and referred him for an urgent cardiology appointment at the local hospital. There is no time target for this, but patients are seen within four weeks where possible.

An appointment was booked for 21 September, five weeks after referral, but postponed by the hospital to 28 September. Sadly, two weeks before the appointment, whilst at work in the staff mess, the man suffered a heart attack. The catering manager, with the help of other prisoners, put the man into the recovery position and called for assistance. Healthcare staff arrived and commenced cardio pulmonary resuscitation (CPR), which paramedics took over when they arrived.

CPR was continued on the way to hospital but was unsuccessful. The man was pronounced dead on arrival at the hospital. His family were already en route to the prison for a visit, as it was the birthday of one of his daughters. They were told the news on arrival, and a member of staff escorted them to the hospital.

INVESTIGATION PROCESS

1. My investigator requested all the relevant documentation including the man's medical records and core prison records. The lead investigator and another of my investigators visited HMP Sudbury during the course of their investigation.

2. Notices to staff and prisoners were sent to the prison to be displayed. These invited anybody with information to talk to my investigators. Following the publication of my draft report, the man's wife told my investigator that a fellow prisoner had written to my office. There is no record of such a letter so my investigator arranged a telephone call with the prison. He told my investigator that the man had been experiencing chest pains for approximately three months. He confirmed that the man was waiting for a hospital appointment which had been delayed and was convinced there was something wrong with his heart. He saw the man the night before he died and commented that he did not look unwell or complain of any ill health.

3. Derbyshire Primary Care Trust (PCT) was asked to carry out a clinical review and the Deputy Director Clinical Quality and Nursing led this on the PCT's behalf. The clinical review was received by my office on 5 March 2008.

4. HM Coroner for Staffordshire was informed of my investigation and provided details of the man's cause of death. He will receive a copy of this report.

5. The man's wife is recorded as his next of kin. One of my Family Liaison Officers contacted her to offer the opportunity of involvement in the investigation. She raised the following matters:

    - That the investigation should consider all aspects of the healthcare her husband received, including when he informed healthcare of the chest pains, what action was taken, and whether this was adequate.

    - That the investigation consider whether he was waiting to be assessed on a walking treadmill that monitors the heart. Did he wait a long time for this and was it postponed? The investigation should consider whether he was waiting an unreasonable length of time for necessary and important tests.

    - For the investigation to look at the emergency response. This should include whether there were staff capable of carrying out CPR close by, and how quickly they were able to respond.

    - For the investigation to consider whether entries made in the man's food diary regarding his chest pain were picked up.

HMP SUDBURY

6. HMP Sudbury is an adult male open prison in the East Midlands. Initially built as a hospital for the US Air Force, Sudbury was converted to a prison in 1948. It has an operational capacity of 571 prisoners.

7. The healthcare centre at Sudbury operates throughout the day during the week and in the mornings at weekend. Her Majesty's Chief Inspector of Prisons last inspected Sudbury on a full announced visit in January 2005, and found that the majority of prisoners rated the quality of healthcare as good or very good. There were good links with the local PCT but there were also some poor practices. These were highlighted again in an unannounced inspection in May 2007, and related in particular to recording procedures, policies and general practitioner (GP) appointments being too short.

8. The prison told my investigator that these areas have been tackled, with a policy review and extended consultation times with the doctor. The issue of recording practices was also being addressed by transferring all prisoner medical notes onto a computerised system. However, the clinical reviewer has found that some recording practices are still deficient.

Glyceryl Trinitrate (GTN)

9. Glyceryl Trinitrate is highly effective in controlling the pain of angina. It opens up the coronary arteries, improving blood supply to the heart muscle. It works quickly but the effect only lasts for a short time. GTN comes as a spray or tablets. (Definition taken from www.nhs.co.uk.)

KEY FINDINGS

10. The man was convicted and sentenced to three years imprisonment in January 2007. He was taken from court to HMP Shrewsbury. When he arrived he was seen by a nurse as part of the reception process. The nurse completed an assessment form to establish his previous and current physical and mental health.

11. When asked if he had any medical problems such as asthma, diabetes or chest pain, he answered "no". (However, later in his sentence he told healthcare staff that he had previously experienced chest pain which had been investigated, but tests had showed nothing abnormal.) He told the nurse of an old knee injury and also that he was taking prescribed anti-depressant medication. The nurse referred him for a doctor's appointment.

12. The records do not give much more information about him over the following three weeks except that he was categorised as a category D prisoner, which meant that he could move to open conditions. He transferred to HMP Sudbury on 20 January 2007. A further reception health assessment was carried out. The man answered "no" to any health problems including a heart condition or any history of heart problems.

13. On 22 January, the man was seen by a visiting doctor. The medical record shows that he felt well and was not depressed, however it was agreed that he would continue with the prescribed anti-depressants.

14. Two months later, on 15 March, the man saw the prison doctor about a back problem which he said he had been experiencing for about ten years. He had requested a better mattress and it was noted in the medical record that his general practitioner (GP) should be consulted for confirmation. The doctor has recorded that, if the mattress was not adequate, then it should be replaced. The clinical reviewer has commented that the man had previously requested a better mattress but not all of these requests were recorded. There is no evidence to suggest that a new mattress was acquired or that his GP was contacted for this information.

15. The record also shows that, during the consultation, the man told the doctor he wished to reduce his anti-depressant medication, and this was agreed. He also told the doctor that he had pain in his calf on exertion. He had apparently been experiencing this for a couple of years so the doctor requested a test to assess the blood flow in his legs.

16. It was noted in the medical record that on 3 April 2007 the pain in the man's calf "was easing". The assessment to check the blood flow still went ahead however, and was performed on 13 April. The results indicated some restriction in the blood flow to the man's leg.

17. At the beginning of May, the prison doctor discussed the issue with the man again. Minor symptoms were continuing but the man did not want

any intervention. The medical record shows that his weight had dropped to 104.3 kg and the doctor prescribed medication to help with continued weight loss. The man was also attending a weight loss clinic at the prison, which included keeping a food diary and taking exercise in the prison gym.

18. During May, the man experienced pain in his left knee. The medical record shows that this may have been aggravated by the exercise he was doing. He was prescribed painkillers and had a blood test. An x-ray was recommended if the pain did not subside. The blood test results were normal but an x-ray was requested at the end of May after the man complained of more pain. This took place on 14 June and the results showed that early osteo-arthritic changes were present in the left knee. The man continued to lose weight and remained on the medication to assist with this. At the end of June he weighed 100.3kg.

19. Also in June, the man resigned from his role as a classroom assistant in education. He wished to undertake an assessor's qualification, and this required him to carry out relevant assessments on others. He felt unable to do this in education and, therefore, secured a new job in the staff mess. It was reported that he worked hard and got on well with his peers and the catering manager.

20. The following month, on 29 July, the man visited the healthcare centre complaining of tightness in his chest after exertion. His medical observations were taken. He was not experiencing pain at the time and no further action was taken. Two weeks later (on 14 August), he went to healthcare again. He had had tightness in his chest but, as before, was not experiencing pain at the time. Blood tests were taken and an appointment made for him to see the doctor.

21. The man saw a prison doctor three days later on 17 August. The clinical reviewer received a statement from the doctor in which she recorded that the man had been concerned that the pain was anginal and had tried to exercise vigorously to see if this reproduced the symptoms. He reportedly found that this was not the case. The doctor wrote in her statement that the man had had similar episodes before arriving in prison which had been investigated, and nothing abnormal had been found. It is not known why he had not given this information on his reception into prison.

22. The doctor requested an urgent cardiology referral at the local hospital and prescribed him with a GTN spray. The aim was to test if the spray would alleviate the pain and help to diagnose if he had angina. The referral form was sent that day. An appointment was given for 21 September but was subsequently postponed by the hospital until 28 September. The hospital operates a Rapid Access Chest Pain Clinic (RACPC), where patients are seen within two weeks, but this was not known to the doctors at the prison. Since receiving my draft report, the doctors have commented that they were aware of a RACPC at another hospital and the prison doctor would have referred him there if she felt it necessary. However, because she

deemed the man's chest pain to be atypical, the doctor felt an urgent referral to the local hospital to see a consultant was appropriate.

23. Between 18 August and 10 September, the man was seen by healthcare staff on several occasions, predominately for painkillers and medical observations. On 4 September, he was given a repeat prescription of his GTN spray by a healthcare nurse. Although, the prescription is documented in the notes, the dosage previously used is not noted. The following day, the man saw the doctor. My investigator has spoken to the prison GP who confirms that he asked the man to tell him about all his episodes of angina. The man told him of three occasions and it was noted in the medical record that he might have had a recent new episode of angina but found quick relief when using the GTN spray. The doctor advised him about calling for assistance if he experienced pain and there was no relief within 15 minutes. The GP told my investigator that at the time he was unaware of the new GTN prescription and could not understand why, when the man told him he had only had three suspected episodes, he would have used the full dose.

24. On 10 September, the man was seen by a nurse and asked her if he could try the medication Omeprazole. He had been speaking to another prisoner who was taking this for what he perceived as similar symptoms. (It appears from the records that the person the man referred to was taking Omeprazole for indigestion.) The nurse explained the signs and symptoms of angina and indigestion and agreed to give him a two week trial on Omeprazole.

25. Also on 10 September, the man wrote to one of the prison governors regarding a forthcoming legal visit. The man attached a second letter, addressed to the Regional Director. In the letter, he praised the compassion and understanding of the staff with whom he had contact and their assistance in trying to re-integrate those under their care back into society. The man had particular praise for the education staff who had helped him plan a teaching career upon his release.

26. On the morning of 12 September, he started work as usual at approximately 8.00am. The statements given by staff after his collapse give different timings, but on balance it appears that between 10.15am and 10.20am, he and the other prisoners had a break for some tea and toast. The man sat in the chair. As he did so, he slumped forward. One of the prisoners called the catering manager who immediately came from the kitchen area. They could not get a response from the man.

27. The manager knew that the man carried a spray for angina, which she took from his pocket and tried, unsuccessfully, to administer. She and two of the other prisoners put him into the recovery position. The catering manager then made a direct call to the healthcare centre. The healthcare

manager sent two nurses to the mess and advised the catering manager to call the central emergency number.

28. Within a few minutes, the nurses from healthcare arrived at the staff mess. The man was initially found to be ”breathing noisily” but then stopped. The nurses did not have a defibrillator with them, but had other emergency equipment including oxygen and oxygen masks. When the man stopped breathing they immediately commenced CPR. The nurses also asked for a defibrillator to be brought to them.

29. An ambulance had been requested by the communications room at 10.22am. However, when the communications room staff were asked about the priority they had to radio the nurses to check. The first response paramedic arrived at approximately 10.37am and began Advanced Life Support (ALS) which involved intubating him. The ambulance crew arrived and took over the situation. The man was then taken to the local hospital by ambulance. The ambulance crew continued CPR and advanced resuscitation (defibrillation and drug administration).

30. Sadly, the resuscitation attempts were not successful and the man was pronounced dead on arrival at the hospital at 11.16am.

Events after the man’s death

31. My investigators asked the prisoners who worked with him if they thought that the man had looked visibly unwell that day, or if he had mentioned feeling unwell. They were told that he looked fine and did not complain of any ill health.

32. One of the prisoners who lived on the same unit had seen the man on the morning of 12 September. He had heard him singing ‘Happy birthday’, and assumed he was on the telephone to his daughter whose birthday it was that day.

33. I have already explained that the man’s wife and children were due to visit him that afternoon. The prison tried to contact the family, but they had already left home to travel to the prison. When they arrived, they were taken aside and told of his death. A member of staff then accompanied them to the hospital.

34. Staff and prisoners in the mess were distressed by the man’s death. They told my investigators that they were given appropriate support, and staff were given the opportunity to discuss matters with the care team. The healthcare team held their own debriefing meeting to provide support as a team and reflect on the events surrounding the man’s death.

35. A memorial service for him was held in the prison on 9 October 2007. My investigators were told that over 40 staff and prisoners attended.

ISSUES

36. The man posed no problems to staff in terms of his behaviour or work within the prison. He was a well liked individual who worked hard and tried to further his education. My investigation has raised no issues or concerns on those matters. The following issues considered are a result of the clinical review into the man's medical care.

Recordkeeping

37. As did the inspection report by HM Chief Inspector of Prisons, the clinical review has highlighted the need for a single recordkeeping format to be adopted. Although the majority of the man's healthcare consultations were entered onto a computerised system, some remained in the paper record alone. Several of these entries are unsigned and use abbreviations unfamiliar to the clinical reviewer however, she was able to have these clarified.

38. After the man was taken to hospital, the record of healthcare staff's attempts to resuscitate him was below the standard expected. The man's medical record was secured after his death was pronounced, as per policy, however staff should have been able to have made an accurate record of the care provided prior to it being secured.

    The Healthcare Manager should arrange a date for the transition to the computerised records system and establish audits to ensure the records conform to professional guidelines. This should also include accurate records of any serious incidents.

Referrals for Secondary Care

39. The man was urgently referred for a cardiology opinion by one of the prison doctors. The referral was dictated and sent the same day that the doctor saw him. The prison doctors were unaware that the local hospital operated a Rapid Access Chest Pain Clinic and therefore did not refer him through this. The clinical reviewer has found that systems for sharing information between clinical practitioners are not robust. Information on service changes is passed on via a mixture of mailshots and briefings. The prison healthcare centre had not been routinely included on such lists, but since the clinical review was undertaken, this has been addressed.

40. This is an issue that the PCT should consider and I draw it to their attention. I would also ask the healthcare manager at Sudbury, in conjunction with the PCT, to ensure that staff are up to date about available services, as well as the waiting times.

41. My investigator asked the clinical reviewer if a referral via the Rapid Access Chest Pain Clinic would have had an impact on the man's life expectancy. Although the panel was unable to give a definitive answer, the likelihood would have been that, even if a diagnosis of ischaemic heart

disease had been confirmed, it would not have prevented his sudden death. It would have been very unlikely that he would have had interventional procedures, for example, angioplasty or coronary artery bypass within the likely timescale. These interventions also only reduce mortality in a few specific situations.

42. The man's wife asked about an exercise test that the man was waiting for. This test was not something that could be carried out in the prison setting, and there would have been a waiting time at the hospital. In terms of any intervention that would have been triggered if the test was positive and a definite diagnosis reached. Under some circumstances a statin would be prescribed, however the man had had a recent abnormal liver test and compromised circulation in his calf. He would not therefore, have been prescribed this. The panel has commented that even if he had been able to take other medication, none would have significantly reduced the short term risk of sudden cardiac death if he had stable angina. There is no definite evidence of unstable angina, for example pain at rest, rapid increase of frequency of attacks or a poor response to the GTN spray, so on balance the panel felt that it was unlikely that the alternative medications would have prevented his sudden death.

43. The clinical reviewer could not find any information about the man's food diary in the prison. From information received by the man's wife, he started keeping it at the end of July. The man's wife was concerned about notes in the diary referring to her husband's chest pain and whether or not these were picked up. The medical records show that it was around this time that the man saw healthcare staff about the tightness in his chest, so they were aware of his condition. He received medication and was referred for a hospital appointment for a full diagnosis.

44. Although he did not let healthcare staff know initially that he had had previous tests for chest pains or that he suffered from back pain, both issues came to light later in his sentence. A prison doctor recommended seeking information from his GP regarding his back pain, but there is no evidence that this was followed up. Similarly, there is no evidence to show that the previous chest pain test results were requested.

    The Healthcare Manager should ensure a process for requesting previous medical records is implemented and audited quarterly.

Medicine Management

45. The man was prescribed a GTN spray as a treatment for possible angina. Two and a half weeks later he had a repeat prescription. The clinical reviewer has noted that the spray contained approximately 200 doses and would have expected this to be reviewed. There is no documented evidence to suggest that an assessment or review took place. Additionally, whilst he saw the doctor the day after the repeat prescription, there is no indication that the doctor was informed about the GTN usage.

46. On 10 September, a nurse prescribed Omeprazole after the man told her about another prisoner who was taking it for similar symptoms. The clinical reviewer has commented that, whilst this was within the nurse's authority, there did not appear to be any clinical indication to prescribe this particular medication. However, there would have been no serious adverse effect to his health.

47. Although not related to the man's death, the clinical reviewer has noted that it was acknowledged by the nurse prescriber that the process for monitoring medication needed to be more robust. She has also noted that the prison does not have an up-to-date medicines code for use by nursing staff.

    The healthcare team should review the policies used by the nurse prescriber and ensure ongoing clinical supervision needs are met.

Managing emergency call outs

48. The catering manager called for healthcare assistance when the man collapsed in the mess, but she telephoned them directly and was then advised to call the central emergency number. The healthcare centre is approximately 345 metres from the staff mess and the nurses were able to respond quickly. They took an emergency bag and oxygen, but not the defibrillator. This was requested once they had assessed the situation. When a call was made for the ambulance, the communication room did not know the priority and had to radio the nurses to check.

49. It is common practice across the Prison Service to use a code system, whether this be a numerical or colour code. For instance a 'code blue' is sometimes used for someone having breathing difficulties, and a 'code red' when somebody is bleeding. By using this system, healthcare staff have a better idea what equipment they need to bring in an emergency. By using a radio or the emergency phone number, all relevant parties can be called quickly from wherever they may be in the prison.

50. Although the response by healthcare in this instance was quick, I recommend that Sudbury adopts a single code system that is easy to use by all staff.

    The Governor and Healthcare Manager should agree a system for medical emergency responses and ensure that all staff are aware of the new procedure.

51. The clinical reviewer reviewed the emergency equipment and found it all to be in good working order. She did find that access to CPR training was limited, although all staff were trained and the training updated.

    The Healthcare Manager should review the access to CPR training and ensure skills are maintained by annual updates. An auditable

updated training record should be established within the next two months.

RECOMMENDATIONS

1. The Healthcare Manager should arrange a date for the transition to the computerised records system and establish audits to ensure the records conform to professional guidelines. This should also include accurate records of any serious incidents.

   HMP Sudbury has accepted this recommendation. Computerised records are now kept.

2. The Healthcare Manager should ensure a process for requesting previous medical records is implemented and audited quarterly.

   HMP Sudbury has accepted this recommendation. All requests for medical records are now logged in a central record, including dates requested, chased and received.

3. The healthcare team should review the policies used by the nurse prescriber and ensure ongoing clinical supervision needs are met.

   HMP Sudbury has accepted this recommendation. Policies relating to the nurse prescriber and non medical prescribing have been reviewed. Appropriate clinical supervision is being sought.

4. The Governor and Healthcare Manager should agree a system for medical emergency responses and ensure that all staff are aware of the new procedure.

   HMP Sudbury has accepted this recommendation. A system for emergency responses is being implemented.

5. The Healthcare Manager should review the access to CPR training and ensure skills are maintained by annual updates. An auditable updated training record should be established within the next two months.

   HMP Sudbury has accepted this recommendation. All healthcare staff are trained. Some non healthcare staff have received defibrillator training and First Aid. Records are in place and planned refresher training documented.